

Aetna Life Insurance Company



New Jersey Life And Health Insurance Guaranty Association Act

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center
9th Floor
Newark, NJ 07102

State of New Jersey
Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

Coverage

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health insurance or long-term care insurance contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons owning such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy was issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

Limitations of Coverage

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than \$500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than \$100,000 in cash surrender values for annuity benefits, \$500,000 in life insurance death benefits or \$500,000 in present value of annuities--again no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

The Association will not pay more than \$2,000,000 in benefits to any one contract holder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

Aetna Life Insurance Company

Group policy

The **group policy** is by and between
Aetna Life Insurance Company
(Aetna, we, us, or our)
and
MONROE TOWNSHIP BOARD OF EDUCATION
(Policyholder, you, or your)

Group policy number: GP-152709-A
Date of issue: July 30, 2020
Effective date: July 1, 2020
Renewal date: July 1
Policyholder situs: New Jersey

This **group policy** takes effect on the **effective date** if we have received your signed group application and the initial **premium**. It remains in force until terminated.

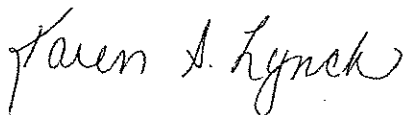
Term of the group policy: The initial term shall be the 12 consecutive month period beginning on the **effective date**.
Subsequent terms shall be the 12 consecutive month period beginning with the **renewal date**.

Premium due dates: The **effective date** and the first day of each succeeding calendar month.

Signed at Aetna's Home Office 151 Farmington Avenue Hartford, Connecticut 06156.

This **group policy** is non-participating.

This **group policy** is governed by applicable federal law and the laws of New Jersey.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Table of contents

	Page
The group policy	5
If you want to discuss your coverage	5
Glossary.....	6
Premium	7
Fees for special services.....	9
Some of our other responsibilities	9
Some of your other requirements and responsibilities.....	10
Termination	13
Intentional deception	14
Responsibility for conduct	14
General provisions	16
Final rates and fees schedule	19

The group policy

The **group policy** consists of several documents taken together. These documents are:

- Your group application
- This **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any riders and amendments to the **group policy**, the booklet-certificate, and the schedule of benefits as stated below

If you want to discuss your coverage

If you have questions about your coverage under the **group policy**, or if you wish to discuss it, contact your agent. If you did not use an agent to purchase your coverage, or if you have additional questions, you may contact us at:

Aetna

151 Farmington Avenue
Hartford, Connecticut 06156
1-800-872-3862

Please have your **group policy** number available when you contact us. It is on the front page of this **group policy**.

Glossary

You will see some words in bold type in the **group policy**. The bold type means we have defined those words.

Covered person

An employee or a dependent of an employee for whom all of the following applies:

- The person is eligible for coverage as defined in the booklet-certificate.
- The person has enrolled for coverage and paid any required **premium** contribution.
- The person's coverage has not ended.

Dates:

Effective date

Date we first cover you under the **group policy**.

Final rates and fees schedule effective date

Date stated on the final rates and fees schedule.

Premium due date

The **effective date** and the first day of each succeeding calendar month.

Renewal date

Date that is 12 months after the **effective date** and each 12 month date thereafter.

Termination date

The date coverage ends according to the *Termination* section.

Policyholder

MONROE TOWNSHIP BOARD OF EDUCATION and entities associated with it for purpose of coverage under this **group policy**.

Premium

Premium – rates and amount due

The premium rates are stated in the *Final rates and fees schedule* section. We will provide you with a new *Final rates and fees schedule* if and when the **premium** rates change. Any new schedule will state its **effective date**.

We charge **premium** based on the **premium** rates in effect on the **premium due date**. The **premium** due on any **premium due date** is the sum of the **premium** charges for the coverage we provide. When we calculate **premium** due, we will use our records to determine who is a **covered person**.

You owe **premium** for a **covered person** starting with the first **premium due date** on or after the day the person's coverage starts. You stop paying **premium** for a **covered person** as of the first **premium due date** on or after the day the person's coverage ends.

Premium – changes in rates

We may change the **premium** rates as of a **premium due date** during the initial term only if:

- There is a change in factors that materially affects the risk we assumed with this coverage. We identify these factors in our rate quote to you.
- There is a change in law or regulation, or there is a judicial decision, that materially affects the cost of providing coverage.

We may change the **premium** rates as of a **premium due date** during any subsequent term.

We will provide 60 days prior written notice to you of any change in **premium** rates.

Premium – experience credit

We may declare an experience credit at the end a plan year. We do not have to declare any experience credit.

If we declare an experience credit, we may return the amount of the credit to you:

- By electronic fund transfer
- By application of the amount to the **premium** due in the current or succeeding plan year, or
- By any other manner that we and you agree to.

We can require you to share an experience credit with your employees in a manner reasonably acceptable to us, as a condition of our giving the credit. If the sum of employee contributions for coverage exceeds the sum of **premium** paid less any experience credits, we will require you to apply at least the excess experience credit for the sole benefit of employees.

Premium – reduction due to performance guarantees

We may agree with you in writing to meet specific levels of service when we administer the **group policy**. We may also agree to reduce our **premium** if we failed to meet the guaranteed levels of service. The reduction is an agreed-upon percent of **premium** due during the period we fail to meet the performance guarantees. We will apply any credit at the end of the plan year, to either prior **premium** paid or to future **premium** due.

Premium – when due

Premium is due on the **premium due date**. You have a payment grace period of 31 days immediately following the **premium due date**. The **group policy** will remain in force during the grace period. If we have not received all **premiums** due by the end of the grace period, this **group policy** will be terminated by us according to the *Termination* section of the **group policy**.

Premium – how billed and paid

We may bill you electronically. You shall pay **premium** due by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Premium – overdue amounts

You shall pay us interest on the total **premium** amount that is overdue. Overdue **premium** includes amounts due but not yet paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

We may also recover from you the costs of collecting any unpaid **premium**, including reasonable attorney fees and costs of suit.

Premium – eligibility corrections

We will retroactively drop a **covered person** from coverage and credit you **premium** payments if:

- The eligibility information included a person who was not eligible for coverage and
- You request that we retroactively drop the person from coverage

Your request that we retroactively drop coverage is your representation that the person did not pay the required **premium** contribution for the period.

We will retroactively cover eligible persons whom you did not include in the eligibility information you provided us. We will cover them retroactively no more than 60 days before the date you both notify us and pay all applicable past **premium**.

Premium – waiver

Payment of premiums

We may waive up to one month's billed **premium** payments during any **group policy** term.

The **premium** waiver will not apply for those employees if after that month's **premium** has been billed, employees are added or removed from the plan coverage. For that month of coverage, additional **premium** will be due or credited.

Repayment of the waived premium

We may require you to pay back the **premium** waived if the **group policy** is terminated within 12 months of your original **effective date**. We will give at least 60 days prior written notice to you of the requirement for the repayment of the waived **premium**.

Fees for special services

Special services

You may request that we provide special services beyond the routine administration of this **group policy**. We will charge you a fee for each special service we provide.

Special services – fees

The special service fees are stated in the *final rates and fees schedule*. We may change any fee on 60 days advance written notice to you. We will provide you with a new *Final rates and fees schedule* if and when the amount of any fee changes. The new schedule will state its **effective date**.

Fees – when due

Fees are due on the **premium due date** immediately following our invoicing you.

Fees – how billed and paid

We may bill you electronically. You shall pay fees by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Fees – overdue amounts

You shall pay us interest on the total amount of fees that is overdue. Overdue fees include amounts due but not paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

We may also recover from you the costs of collecting any unpaid fees, including reasonable attorney fees and costs of suit.

Some of our other responsibilities

We will prepare the booklet-certificate and schedule of benefits that are part of the **group policy**, as required by applicable federal and state laws. We will provide them to you in electronic form. We will also provide them to you in paper form if you request it.

We will provide the coverage stated in the booklet-certificate and schedule of benefits that are part of the **group policy**. We will administer the coverage as required by the **group policy** and applicable federal and state laws.

We will protect the personal health information of **covered persons** as required by federal and state laws. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help us process **providers'** claims and otherwise help us administer the **group policy**. For a copy of our Notice of Privacy Practices, call Member Services at 1-877-238-6200 or log on to www.aetna.com.

Our duties in this section survive termination of the **group policy**.

Some of your other requirements and responsibilities

Participation and contribution

You must comply with our participation and contribution requirements.

Distribution – booklet-certificate and schedule of benefits

You will distribute as required by applicable federal and state laws, the booklet-certificate and schedule of benefits that we provide you.

Information – access

You shall make payroll and other records directly related to a person's coverage under this **group policy** available to us for inspection. This will occur:

- Upon our reasonable advance request
- At our expense
- At your office
- During regular business hours

Your duties and our rights in the Information – access provision survive termination of the **group policy**.

Information – eligibility

You shall send us eligibility information we request to administer the **group policy**. We will request the information monthly or as otherwise required. You will send us the information on our form, or through such other means, as we require.

The eligibility information includes but is not limited to data needed to:

- Enroll your employees and their dependents
- Process terminations
- Make changes in family status

By sending the information to us, you represent that it is correct. You acknowledge that we can and will rely on the information.

You shall:

- Maintain a reasonably complete record of the information you send us for at least seven years, and until the final rights and duties under the **group policy** have been resolved.
- Send us information you sent us before, upon request

We will not start covering a person under the **group policy** until you send us the information to enroll that person. Subject to applicable federal and state laws and the **group policy**, we will not stop covering a person until you send us the information to terminate coverage.

You shall notify us within 15 business days of the date in which:

- An employee's employment ceases, or
- A dependent loses eligibility under the **group policy**

You must notify us when a request for retroactive termination is a result of a **covered person**:

- Performing an act or omission that constitutes fraud, or
- Making an intentional misrepresentation of material fact

to get coverage or to get a benefit under the **group policy**.

Your duties and our rights in this Information – eligibility provision survive termination of the **group policy**.

Notices – termination of coverage

You shall notify **covered persons** in writing, of their rights when coverage stops.

In particular, you shall notify all eligible **covered persons** of their right to continue coverage pursuant to the *Special coverage options after your plan coverage ends* provisions in the booklet-certificate and applicable federal and state laws. Your notification will include:

- A description of plans available
- **Premium** rates
- Application forms

You will give the notification within 15 calendar days to a person becoming eligible for continuation coverage.

Your duties and our rights in this provision survive termination of the **group policy**.

Workers' compensation coverage

You must comply with workers' compensation coverage laws applicable to your employees covered by the **group policy**. Prior to the **effective date** and upon our request after the **effective date** you will provide us reasonable evidence of your satisfying applicable workers compensation coverage laws.

You will provide us with monthly reports of all workers' compensation coverage cases. The report will list for each case, the employee name, identifying number, date of loss and diagnosis.

Termination

Automatic termination

The **group policy** and all coverage end as of the last day of the grace period if you have not paid us all **premiums** and fees due as of the beginning of the grace period. The grace period is described in the *Premium* section.

Termination by you

You may end coverage under this **group policy** if you give us 30 days advance written notice. Your termination notice may apply to all classes or any class of your employees covered under the **group policy**. You can send us a termination notice during a period for which you have paid **premium**, but your **termination date** must be after that period.

Termination by us

We may end the **group policy** and all coverage it provides:

- We will give you 60 days advance written notice before we end your coverage. The notice will state the **effective date** of rescission:
 - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage
 - If you are a member of an association and your membership in the association ceases
- Upon 30 days written notice to you:
 - If you breach a provision of the **group policy** and you do not cure the breach within the notice period
 - If you cease to be a group as defined under applicable state law
 - If you fail to meet our contribution or participation requirements applicable to this **group policy**
 - If you do not certify your compliance with our policies and procedures upon request
 - If you change your eligibility or participation requirements without our consent
- Upon 90 days written notice to you (or such longer notice period as applicable federal and state laws requires,) if we cease to offer the product lines provided by this **group policy**.
- Upon 90 days written notice to you (or such longer notice period as applicable federal and state laws requires,) if we act as required by applicable federal and state laws for uniform termination of coverage.

Non-renewal for failure to respond

We may request that you tell us whether you intend to renew the **group policy**. You must reply:

- Within two weeks of your receipt of the request or
- Within 15 days prior to the **renewal date**

whichever is later. Your reply must be in writing unless we authorize an oral reply. If you do not reply, we will not continue coverage on and after the **renewal date** and:

- You will owe us any unpaid **premium**
- We will owe you a refund if you overpaid **premium**.

Effective time of termination

The **group policy** and its coverage end at 11:59 p.m. on the day of termination.

Effect of termination

You, **covered persons**, and we continue to be responsible following termination for the duties we each incur prior to the termination of the **group policy**. One of your duties includes payment of **premium** due for coverage through any grace period up to the day of termination. You, **covered persons**, and we also continue to be responsible for your, their, and our duties that the **group policy** states are to occur following termination.

You, **covered persons**, and we have the rights and duties following termination of the **group policy**, as stated specifically in the **group policy**.

You shall notify **covered persons** of the termination of the **group policy**. Your notice will comply with applicable federal and state laws. We have the right to notify employees of termination of the **group policy**.

Reinstatement

You may request that we reinstate the **group policy** and coverage after we end it. You must make the request within 30 days of the **termination date**. We will reinstate the **group policy** as of the **termination date** upon payment of all amounts due, and you giving us reasonable assurances that you can and will fulfill all of your obligations under the **group policy**.

Intentional deception

If we learn that you or a **covered person** defrauded us or that a **covered person** intentionally misrepresented material facts, we can and may take actions that can have serious consequences for coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward
- Denial or termination of benefits
- Recovery of amounts we already paid

We also may report fraud to law enforcement.

Rescission means you or a **covered person** loses coverage both going forward and going backward. If we paid claims for past coverage, we are entitled to receive the money back.

A **covered person** has special rights if we rescind coverage just for that individual:

- We will give the **covered person** 60 days advance written notice of any rescission of coverage.
- The **covered person** has the right to an **Aetna** appeal.

Responsibility for conduct

Employees and agents

We are responsible to you for what our employees and other agents do.

We are not responsible to you for what is done by others, such as **providers**. They are not our employees or agents. **Providers** in our network are what the law calls our independent contractors. That simply means we have a business relationship with them and they are not our employees or agents.

Indemnification – in general

We agree to indemnify and hold you harmless against that portion of your liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by our willful misconduct, criminal conduct or material breach of this **group policy**.

You agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your negligence, breach of the **group policy**, breach of applicable federal and state laws, willful misconduct, criminal conduct or fraud.

These indemnification obligations end with the **group policy**, except as to any matter concerning a claim that has been made in writing within 365 days after termination.

Indemnification – federal law requirements

You shall indemnify us and hold us harmless for our liability that is directly caused by your:

- Negligence
- Breach of the **group policy**
- Breach of federal and state laws that apply or
- Willful misconduct

and by your act or failure to act that was related to or arose out of your obligation to deliver the Summary of benefits and coverage and Notices of material modification.

Your and our rights and duties in this *Responsibility for conduct* section survive termination of the **group policy**.

General provisions – content and interpretation of the group policy

Applicable law

Applicable law means all federal and state laws that apply to the matters covered by the **group policy**. Federal and state law means: statutes, regulations, official agency direction and guidance, and judicial decisions and orders, as they may be passed or issued, or as they may be amended, from time to time.

Compliance with law

You and we shall interpret the **group policy**, if possible, so it complies with applicable federal and state laws.

If the **group policy** omits or misstates any right or duty under applicable federal and state laws, you and we shall implement the **group policy** as though the right or duty is stated correctly in the **group policy**.

If any provision of the **group policy** is invalid or illegal, you and we shall implement the **group policy** as though the provision is not in the **group policy**.

Changes to the group policy

The **group policy** may be amended by a writing to which we both consent.

We may change or end some or all coverage under this **group policy** by notice, if we act as required by applicable federal and state laws for uniform modification of coverage and uniform termination of coverage.

We may amend the **group policy** by notice. We must give you 60 days advance written notice. Our amendment:

- Will not reduce benefits or coverage
- Will not eliminate benefits or coverage or
- Will not increase benefits or coverage with a concurrent increase in **premium** during the current **group policy** term, other than increased benefits or coverage required by law.

Written consent or payment of the applicable **premium** on the **effective date** of any amendment is your consent to any amendment requiring your consent.

Changes to the **group policy** do not require the consent of any employee or of any other person. All agreements made by us are signed by an authorized executive officer of **Aetna**. Only an authorized officer of **Aetna** may change or waive any of the policy terms or make any agreement binding us.

The **group policy** shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations. You will not have to give written policy of a change in the **group policy** if:

- You asked for the change and we have agreed to it.
- The change is needed to correct an error in the **group policy**, including any booklet-certificate issued to anyone.
- The change is needed so that the **group policy** will conform to any law, regulation or ruling of a jurisdiction that affects a person covered under this **group policy**; or the Federal Government.
- We initiated the change and this change will not result in either a reduction or elimination in benefits or coverage or an increase in **premium**.

You will have to give written policy of a change in the **group policy**:

- That reduces or eliminates benefits or coverage or
- That increases benefits or coverage with a concurrent increase in **premium** during the policy term, except if the increased benefits or coverage is required by law.

Payment of the applicable **premium** after notice of the proposed changes will be deemed to constitute your written policy of those changes on behalf of all persons covered under this **group policy**.

Entire group policy

The **group policy** replaces and supersedes:

- All other prior group policies of vision coverage between us
- Any other prior written or oral understandings, negotiations, discussions or arrangements between us related to this vision coverage

Waiver

Only an officer of **Aetna** may waive a requirement of the **group policy**.

We may fail to implement or fail to insist upon compliance with a provision of the **group policy** at any given time or times. Our failure to implement or to insist on compliance is not a waiver of our right to implement or insist upon compliance with that provision at any other time or times.

General provisions – administration of the group policy

Aetna name, symbols, trademarks and service marks

We control the use of our name and of our symbols, trademarks and service marks presently existing or subsequently established. You shall not use any of them in advertising or promotional materials or in any other way without our prior written consent. You shall stop any and all use immediately upon our direction or upon termination of the **group policy**.

Assignment and delegation

You shall not assign any right or delegate any duty under the **group policy** unless we approve it in writing in advance.

We may delegate some of our functions under the **group policy** to third parties. We may also change or end these delegations. We do not need to give you advance notice to enter into, change or end these arrangements, and we do not need your consent.

Claim determinations

We have complete authority to review all denied claims for benefits under this **group policy**:

- To determine whether and to what extent **covered persons** are entitled to benefits
- To construe any disputed or doubtful terms under the **group policy**. We shall be deemed to have properly exercised our authority unless we abuse our authority by acting arbitrarily and capriciously.

Our review of claims for benefits may include the use of software and other tools to take into account factors such as:

- An individual's claim history
- A **provider's** billing patterns
- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

Correcting our administrative errors

A clerical error in keeping records or a delay in making an entry will not alone determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in **premium** if correction of the error or delay changes coverage.

We may correct, withdraw, or replace the **group policy**, any booklet-certificate, any schedule of benefits and any other document issued with an error or issued in error.

Correcting your honest mistakes

If you or any employee make an honest mistake of fact, we may make a fair change in premium. If the misstatement affects the existence or amount of coverage, we will use the true facts to determine whether coverage is or remains in effect and its amount.

Discrimination prohibited

You shall not encourage or discourage enrollment in the coverage provided by the **group policy** based on health status or health risk.

You shall act so as not to discriminate unfairly between persons in like situations at the time of the action.

Financial Sanctions Exclusions

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, we cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Incontestability

We will not use a statement you make to void this **group policy** after it has been in force for 2 years from its **effective date**.

We will use only a statement in writing that you or a **covered person** makes, to do any of the following:

- To void coverage of the **covered person**
- To deny coverage of the **covered person**
- To deny a claim for benefits by the **covered person**

We will not use a statement by a **covered person** to deny a claim for benefit more than 2 years after the statement was made.

Notices

The **group policy** requires or permits notice to each other. These notices shall be in writing.

Notice may be delivered:

- In person, and is effective upon delivery
- By United States mail, sent first class, postage prepaid, and is effective three U.S. Postal Service delivery days following the date of mailing
- By commercial carriers UPS and FedEx, effective upon delivery
- By e-mail, facsimile or other electronic means, effective upon sending.

Notice sent to us by mail and commercial carrier shall be sent to:

Aetna

151 Farmington Avenue
Hartford, Connecticut 06156

Notice sent to you by mail and commercial carrier shall be sent to:

MONROE TOWNSHIP BOARD OF EDUCATION

Attention: Michael Gorski, Bus Admin/Board Secretary

423 Buckelew Ave
Monroe Township, NJ 08831

You and we must designate specific e-mail addresses, facsimile numbers or other electronic means in writing for purpose of notices.

Policies and procedures

We have the right to adopt reasonable policies, procedures, and rules of the **group policy** in order to promote orderly and efficient administration. You and all [**covered persons**] are bound by and shall comply with them. You will certify your compliance with them upon our request or as required specifically by the **group policy**. We have the discretion to make an initial interpretation as to the terms of the policy or contract, but that such interpretation can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction.

Third parties rights

This **group policy** does not give any rights or impose any duties on third parties except as specifically stated.

Final rates and fees schedule

The current **premium** rates for all of the coverages provided under the policy are on record with us and the **policyholder**.



Vision Plan

Schedule of benefits

Prepared exclusively for:

Policyholder: Monroe Township Board of Education
Group policy number: GP-152709-A
Schedule of Benefits 1A
Group policy effective date: July 1, 2020
Plan effective date: July 1, 2020
Plan issue date: May 28, 2021
Plan revision effective date: July 1, 2021

Underwritten by Aetna Life Insurance Company in the state of New Jersey.

Schedule of benefits

This schedule of benefits lists the **eligible vision services** and supplies, 24 consecutive month period maximums, if any, that apply to the services you get under this plan.

How to read your schedule of benefits

- You are responsible for full payment of any vision care services you get that is not a **covered benefit**
- Exceeds your 24 consecutive month period maximum.

How to contact us for help

We are here to answer your questions.

- Log onto your secure member website at www.aetna.com.
- Call Member Services

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your booklet-certificate.

General coverage provision

This section explains the vision supply maximum listed in this schedule of benefits.

Maximum vision supply

The most the plan will pay for **eligible vision services** incurred by any one covered person in a 24 consecutive month period is called a vision supply maximum.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan feature

Eligible vision services	Maximum benefit
Vision care services and supplies	\$70 per 24 consecutive month period
Coverage does not include the office visit for the fitting of prescription contact lenses	

Aetna Life Insurance Company

Amendment

Policyholder: Monroe Township Board of Education

Group policy number: GP-152709

Amendment effective date: July 1, 2021

Your group policy has changed. The certificate of coverage has been revised to reflect this. This change is effective on the date shown above.

The *Fertility preservation* provision eligible health services has been revised as follows:

Eligible health services for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are infertile. Fertility preservation will be allowed even if the member has egg/embryos currently stored.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Dan Finke

Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Fertility benefit
Amendment 5
Issue Date: May 28, 2021

Aetna Life Insurance Company

Amendment

Policyholder: Monroe Township Board of Education

Group policy number: GP-152709

Amendment effective date: July 1, 2021

Your group policy has changed. The schedule of benefits has been revised to reflect this. This change is effective on the date shown above.

The *Orthotic or prosthetic devices* provision of the schedule of benefits has been revised to separate ostomy supplies as follows:

Ostomy supplies	\$0 per item
	No deductible applies

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Dan Finke

Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Amendment

Policyholder: Monroe Township Board of Education

Group policy number: GP-152709

Amendment effective date: July 1, 2021

Your group policy has changed. The schedule of benefits has been revised to reflect this. This change is effective on the date shown above.

The *Orthotic or prosthetic devices* provision of the schedule of benefits has been revised to separate ostomy supplies as follows:

Ostomy supplies	\$0 per item	20% (of the recognized charge) per item
	No deductible applies	

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Dan Finke

Chairman, Chief Executive Officer and President Aetna

Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Amendment

Policyholder: Monroe Township Board of Education

Group policy number: GP-152709

Amendment effective date: July 1, 2021

Your group policy has changed. The schedule of benefits has been revised to reflect this. This change is effective on the date shown above.

The *Orthotic or prosthetic devices* provision of the schedule of benefits has been revised to separate ostomy supplies as follows:

Ostomy supplies	\$0 per item No deductible applies	30% (of the recognized charge) per item
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This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Dan Finke

Chairman, Chief Executive Officer and President Aetna

Life Insurance Company
(A Stock Company)

Open Access Managed Choice \$20 Plan-Ostomy Benefit
Amendment 8
May 28, 2021

Aetna Life Insurance Company

Amendment

Policyholder: Monroe Township Board of Education

Group policy number: GP-152709

Amendment effective date: July 1, 2021

Your group policy has changed. The Booklet for the New Jersey Educator Health Plans has been revised to reflect this. This change is effective on the date shown above.

The *Oral and maxillofacial treatment (mouth, jaws and teeth)* provision of the Booklet has been revised as follows:

Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a **physician**, a dentist and **hospital**:

- Non-surgical treatment of infections or diseases.
- Surgery needed to:
 - Treat a fracture, dislocation, or wound
 - Cut out cysts, tumors, or other diseased tissues.
 - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
 - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your or your dependent's condition.
- Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:
 - Natural teeth damaged, lost, or removed. Your or your dependent's teeth must be free from decay or in good repair, and are firmly attached to your or your dependent's jaw bone at the time of your or your dependent's **injury**.
 - Other body tissues of the mouth fractured or cut due to **injury**.
- Crowns, dentures, bridges, or in-mouth appliances only for:
 - The first denture or fixed bridgework to replace lost teeth.
 - The first crown needed to repair each damaged tooth.
 - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.
- Accidental **injuries** and other trauma. Oral **surgery** and related dental services to return sound natural teeth to their pre-trauma functional state. These services must take place no later than 24 months after the **injury**.
 - Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
 - If a child needs oral **surgery** as the result of accidental **injury** or trauma, **surgery** may be postponed until a certain level of growth has been achieved.

The *General exceptions section – Dental care* has been revised as follows:

Dental care except as covered in the *Eligible health services under your plan* Oral and maxillofacial treatment section.

Dental services related to:

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Bony impacted teeth
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include bone fractures, removal of tumors, and odontogenic cysts or preventive dental services for children.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.



Dan Finke

Chairman, Chief Executive Officer and President Aetna

Life Insurance Company
(A Stock Company)

BENEFIT PLAN

**Prepared Exclusively For
Monroe Township Board of Education**

Passive PPO Dental

**What Your Plan
Covers and How
Benefits are Paid**

**Aetna Life Insurance Company
Booklet-Certificate**

This Booklet-Certificate is part of the Group Insurance Policy
between **Aetna** Life Insurance Company and the Policyholder





**Preferred Provider Organization (PPO)
Dental Insurance Plan**

Booklet-Certificate

Prepared exclusively for

Policyholder: Monroe Township Board of Education

Policyholder number: 152709

Booklet-certificate 1

Group policy effective date: July 1, 2020

Plan effective date: July 1, 2020

Plan issue date: June 25, 2020

Underwritten by Aetna Life Insurance Company

Welcome

Thank you for choosing **Aetna**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan for in-network and out-of-network coverage.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the **group policy**, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for **eligible dental services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the **group policy** between **Aetna Life Insurance Company** (“**Aetna**”) and the policyholder. Ask the policyholder if you have any questions about the **group policy**.

Sometimes, we may send you documents that are amendments, endorsements, attachments, inserts or riders. They change or add to the documents that they’re part of. When you receive these, they are considered part of your **Aetna** plan for coverage.

Where to next? Try the *Let’s get started!* section. *Let’s get started!* gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

Table of Contents

	Page
Welcome	
Let's get started!.....	1
Who the plan covers	4
Medical necessity requirements	7
What are your eligible dental services?.....	8
What rules and limits apply to dental care?	9
An advance claim review.....	12
What your plan doesn't cover – some eligible dental service exceptions and exclusions	13
Who provides the care?	16
What the plan pays and what you pay	17
When you disagree - claim decisions and appeals procedures	19
Coordination of benefits (COB).....	23
When coverage ends.....	27
Special coverage options after your plan coverage ends.....	30
General provisions – other things you should know	36
Glossary.....	40
Schedule of benefits	Issued with your booklet-certificate

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words in the booklet-certificate and schedule of benefits

- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean **Aetna**.
- Some words appear in **bold** type and we define them in the *Glossary* section.

Sometimes we use technical dental language that is familiar to **dental providers**.

What your plan does – providing covered benefits

Your plan provides in-network and out-of-network **covered benefits**. These are **eligible dental services** for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage helps you:

- Get and pay for a lot of – but not all – dental care services. These are called **eligible dental services**
- Pay less cost share when you use a **in-network provider**

Important note:

See the schedule of benefits for any **deductibles**, **coinsurance**, and maximum age or visit limits that may apply.

Eligible dental services

Eligible dental services meet these requirements:

- They are listed in the *Eligible dental services* section in the schedule of benefits.
- They are not carved out in the *What your plan doesn't cover – some eligible dental service exceptions and exclusions* section. (We refer to this section as the “Exceptions” section.)
- They are not beyond any limits in the schedule of benefits.

Aetna's network of dental providers

Aetna's network of **dental providers** is there to give you the care you need. You can find **in-network providers** and see important information about them most easily on our online **directory**. Just log into your secure member website at www.aetna.com or call us at 1-877-238-6200.

You can choose any **dental provider** who is in the dental network.

Your plan often will pay a bigger share for **eligible dental services** that you get through **in-network providers**, so choose **in-network providers** as soon as you can.

For more information about the **directory** and the role of your **dental provider**, see the *Who provides the care* section.

Paying for eligible dental services– the general requirements

There are general requirements for the plan to pay any part of the expense for an **eligible dental service**. They are:

- The **eligible dental service** is **medically necessary**.
- You get the **eligible dental services** from **in-network** or **out-of-network providers**.

You will find details on **medical necessity** requirements in the *Medical necessity* section.

Paying for eligible dental services– sharing the expense

Generally your plan and you will share the expense of your **eligible dental services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

How your plan works while you are covered out-of-network

The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from **providers** who are not part of the **Aetna** network. It's called out-of-network coverage.

Your out-of-network coverage:

- Means you can get care from **dental providers** who are not part of the **Aetna** network.
- Means you may have to pay for services at the time that they are provided. You maybe required to pay the full charges for your services.
- Means you will pay a higher cost share when you use an **out-of-network provider**.
- Means you will not have to submit claims for treatment received from **out-of-network providers**. Your **out-of-network providers** will take care of that for you.
- Means you may also submit a claim for reimbursement to us if you choose.
- Means we will directly pay the **out-of-network provider** for what the plan owes.

You will find details on:

- **Out-of-network providers** and any exceptions in the *Who provides the care?* section. Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your questions. You can contact us by:

- Logging onto your secure member website at www.aetna.com
- Registering for our secure Internet access to reliable dental information, tools and resources

Online tools will make it easier for you to make informed decisions about your dental care, view claims, research care and treatment options, and access information.

You can also contact us by:

- Calling **Aetna Member Services** at 1-877-238-6200
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Your member ID card

You don't need to show an ID card. When visiting a **dentist**, just provide your name, date of birth and either your member ID or social security number. The dental office can use that information to verify your eligibility and benefits. Your member ID is located on the front of your digital ID card which you can view or print by going to the secure member website at www.aetna.com. If you don't have internet access, call us at 1-877-238-6200. You can also access your ID card when you're on the go. To learn more, visit us at www.aetna.com/mobile.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

The policyholder decides and tells us who is eligible for dental care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At the end of any waiting period the policyholder requires
- At any time
- Once each **Calendar Year** during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself and your dependents when you first qualify for dental benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your “dependents”.)

- Your spouse, including a civil union partner as defined by New Jersey State law. We also mean civil union or civil union partner when we talk about:
 - Husband/wife (spouse)
 - Family/immediate family
 - Dependent
 - Next of kin
- We mean civil union when we talk about:
 - Marriage
 - Widow/widower/widowed

- Your domestic partner established in New Jersey prior to February 19, 2007 as evidenced by a copy of an Affidavit of Domestic Partnership filed with the local registrar and marked as “filed”.
- A domestic partnership providing all of the rights and benefits of marriage valid in another state will be valid for this benefit plan.
- Your dependent children – your own or those of your spouse or domestic partner who are:
 - Under age 23
 Children include:
 - Your biological children
 - Your stepchildren
 - Your legally adopted children
 - Your foster children, including any children placed with you for adoption
 - Any children you are responsible for under a qualified medical support order or court-order (without regard to whether or not the child resides with you)
 - Your grandchildren in your court-ordered custody
- We will not refuse to enroll your child because he or she:
 - Was born out of wedlock
 - Is not claimed as a dependent on your federal tax return
 - Does not live with you or in your service area

You may continue coverage for a disabled child past the age limit shown above. See the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
 - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
 - Ask the policyholder when benefits for your spouse will begin. It will be:
 - No later than the first day of the first calendar month after the date we receive your completed enrollment information
 - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership valid in another state, you can enroll your domestic partner on your dental plan.
 - We must receive your completed enrollment information not more than 31 days after the date you enter into the domestic partnership.
 - Ask the policyholder when benefits for your domestic partner will begin. It will be:
 - No later than the first day of the calendar month after the date we receive your completed enrollment information and
 - Within 31 days of the date of entering into the domestic partnership.
- A newborn child – Your newborn child is covered on your dental plan from the moment of birth and for the first 31 days after birth.
 - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
 - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** for the covered dependent.
 - If you miss this deadline, your newborn will not have dental benefits after the first 31 days.

- An adopted child – A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete.
 - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption.
 - If you miss this deadline, your adopted child will not have dental benefits after the first 31 days.
- A stepchild – You may put a child of your spouse or domestic partner on your plan.
 - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
 - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Inform us of any changes

It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other group dental plan

Late entrant rule

Except for the newborn coverage described above, the plan does not cover services and supplies given to a person age 5 or older if that person did not enroll in the plan during one of the following:

- The first 31 days the person is eligible for this coverage or
- Any period of open enrollment agreed to by the policyholder and us

This does not apply to charges incurred for any of the following:

- After the person has been covered by the plan for 12 months
- As a result of **injuries** sustained while covered by the plan
- Diagnostic and preventive services such as exams, cleanings, fluoride, and images (orthodontia related services are not included).

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
 - You were covered by another group dental plan, and now that other coverage has ended.
 - You had COBRA, and now that coverage has ended.
- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- When a court orders that you cover a current spouse or domestic partner, or a minor child on your dental plan.

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage will be in effect as of the date you become eligible for dental benefits.

Medical necessity requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible dental services**. See the *Eligible dental services* and *What your plan doesn't cover – some eligible dental services exceptions and exclusions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible dental services** only if the **eligible dental service** is **medically necessary**.

This section addresses the **medical necessity** requirements.

Medically necessary / medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are in the *Glossary* section, where we define "**medically necessary, medical necessity**."

What are your eligible dental services?

The information in this section is the first step to understanding your plan's **eligible dental services**. If you have questions about this section, see the *How to contact us for help* section.

Your plan covers many kinds of dental care services and supplies. Your **eligible dental services** are listed in the schedule of benefits. There you will find the detailed list of Type A, Type B and Type C **eligible dental services**. But sometimes those services are not covered at all or are covered only up to a limit.

You can find out about exclusions in the *What your plan doesn't cover – some eligible dental service exceptions and exclusions* and the *What rules and limits apply to dental care?* sections, and about the limitations in the schedule of benefits.

Dental emergency

Eligible dental services include dental services provided for a **dental emergency**. The care provided must be a **covered benefit**.

If you have a **dental emergency**, you should consider calling your dental **in-network provider** who may be more familiar with your dental needs. However, you can get treatment from any **dentist** including one that is an **out-of-network provider**. If you need help in finding a **dentist**, call Member Services.

What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

Alternate treatment rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service or supply and an **eligible dental service** that would provide an acceptable result, then your plan will pay a benefit for the **eligible dental service** or supply.

If a charge is made for an **eligible dental service** but another **eligible dental service** that would provide an acceptable result is less expensive, the benefit will be for the least expensive **eligible dental service**.

The benefit will be based on the **in-network provider's negotiated charge** for the **eligible dental service** or, in the case of an **out-of-network provider**, on the **recognized charge**.

You should review the differences in the cost of alternate treatment with your **dental provider**. Of course, you and your **dental provider** can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

Coverage for dental work begun before you are covered by the plan

Your plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

Orthodontic treatment rule

Orthodontic treatment is covered on the date active **orthodontic treatment** begins.

This benefit does not cover charges for the following:

- Replacement of broken appliances
- Re-treatment of orthodontic cases
- Changes in treatment necessitated by an accident
- Maxillofacial surgery
- Myofunctional therapy
- Treatment of cleft palate
- Treatment of micrognathia
- Treatment of macroglossia
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces")

The plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the plan.

Orthodontic limitation for late enrollees

The plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the 2 year period starting with the date you became covered by the plan. This limit applies only if you do not become enrolled in the plan within 31 days after you first become eligible.

Reimbursement policies

We have the right to apply **Aetna** reimbursement policies. Those policies may reduce the **negotiated charge** or **recognized charge**. These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the **provider**

Aetna reimbursement policies are based on our review of:

- The Centers for **Medicare** and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of dental practice and
- The views of **providers** and **dentists** practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

If you owe a **copayment**, these reimbursement policies will not affect what you owe. If you owe **coinsurance**, then the lower **negotiated charge** will mean your **coinsurance** is lower also.

Replacement rule

Some **eligible dental services** are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Implants
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These **eligible dental services** are covered only when you give us proof that:

- While you were covered by the plan:
 - You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
 - As a result, you need to replace or add teeth to your denture or bridge.
- The present item cannot be made serviceable, and is:
 - A crown installed at least 5 years before its replacement.
 - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 5 years before its replacement.
- While you were covered by the plan:
 - You had a tooth (or teeth) extracted.
 - Your present denture is an immediate temporary one that replaces that tooth (or teeth).
 - A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Congenital defects treatment rule

- For newly born children, dental benefits are provided for medically diagnosed congenital defects and birth abnormalities to the same extent as other dental conditions. Any waiting periods will apply.

An advance claim review

The purpose of an advance claim review is to provide an estimate, in advance, of what we may pay for proposed services. Knowing ahead of time which services are **eligible dental services** and what your plan may pay helps you and your **dentist** make informed decisions about the care you are considering. The estimate is not a guarantee of coverage and payment.

In estimating the amount of benefits payable, we will look at alternate procedures, services, or courses of treatment for the dental condition in question in order to meet the expected result.

The estimate is voluntary. It should not be considered for **dental emergency services** or routine care such as cleaning teeth or check-ups or any other service.

When to get an advance claim review

An estimate is recommended whenever a course of dental treatment is likely to cost more than \$350. Here are the steps involved with getting an advance claim review:

1. Ask your **dentist** to write down a full description of the treatment you need. They must either use an **Aetna** claim form or an American Dental Association (ADA) approved claim form.
2. Your **dentist** should send the form to us before treating you.
3. We may request supporting images and other diagnostic records.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the estimated benefits payable.
5. You and your **dentist** can then decide how to proceed.

What is a course of dental treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

What your plan doesn't cover –some eligible dental service exceptions and exclusions

In this section we tell you about the exceptions and exclusions that apply to your plan.

And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

Exceptions and exclusions

The following are not **eligible dental services** under your plan except as described in:

- The *What are your eligible dental services?* section of this booklet-certificate or
- A rider or amendment issued to you for use with this booklet-certificate:

Charges for services or supplies

- Provided by **in-network providers** in excess of the **negotiated charge**
- Provided by an **out-of-network provider** in excess of the **recognized charge**
- Provided for your personal comfort or convenience, or the convenience of any other person, including a **dental provider**
- Provided in connection with treatment or care that is not covered under the plan
- Cancelled or missed appointment charges or charges to complete claim forms
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage, including:
 - Care in charitable institutions
 - Care for conditions related to current or previous military service
 - Care while in the custody of a governmental authority

Charges in excess of any benefit limits

Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

Cosmetic services and plastic surgery

- **Cosmetic** services and supplies including:
 - Plastic surgery
 - Reconstructive surgery
 - **Cosmetic** surgery
 - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
 - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach, alter the appearance of teeth whether or not for psychological or emotional reasons
- Facings on molar crowns and pontics will always be considered **cosmetic**

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.

Dental services and supplies

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
 - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
 - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another **eligible dental service**
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- **Orthodontic treatment** except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- **Temporomandibular joint dysfunction/disorder**

Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan
- Under any other plan of group benefits provided by the policyholder

Examinations

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a court order requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures

Non-medically necessary services

- Services, including but not limited to, those treatments, services, prescription drugs and supplies which are not **medically necessary** (as determined by **Aetna**) for the diagnosis and treatment of **illness, injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Other health professionals

- Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:
 - Scaling of teeth
 - Cleaning of teeth
 - Topical application of fluoride
- Charges submitted for services by an unlicensed **provider** or not within the scope of the **provider's** license.

Other primary payer

- Payment for a portion of the charge that another party is responsible for as the primary payer

Outpatient prescription drugs, and preventive care drugs and supplements

- Prescribed drugs, pre-medication or analgesia

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Services paid under your medical plan

- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

Work related illness or injuries

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
- If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "not work related" regardless of cause.

Who provides the care?

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible dental services**, the foundation for getting covered care is through our network. This section tells you about **in-network** and **out-of-network providers**.

In-network providers

We have contracted with **dental providers** to provide **eligible dental services** to you. These **dental providers** make up the network for your plan. For you to receive the network level of benefits you must use **in-network providers** for **eligible dental services**.

For you to receive the **in-network** level of benefits you must use **in-network providers** for **eligible dental services**.

The exceptions are:

- **Dental emergency services** – Refer to the *What are your eligible dental services* section
- **In-network providers** are not available to provide the service or supply that you need

You may select **in-network providers** from the **directory** or by logging on to our website at www.aetna.com. You can search our online **directory** for names and locations of **dental providers** or call us at 1-877-238-6200.

You will not have to submit claims for treatment received from **providers**. Your **provider** will take care of that for you. And we will directly pay the **in-network provider** for what the plan owes.

Out-of-network dental providers

You also have access to **out-of-network providers**. This means you can receive **eligible dental services** from an **out-of-network provider**. If you use an **out-of-network provider** to receive **eligible dental services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims

What the plan pays and what you pay

Who pays for your **eligible dental services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **deductible**
- Your **coinsurance**
- Your **maximums**

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an **eligible dental service**.

The general rule

When you get **eligible dental services**:

- You pay your **deductible**

And then

- Your plan and you share the expense up to any **Calendar Year** and **lifetime maximum**. The schedule of benefits lists how much you pay and how much your plan pays. The **coinsurance** percentage may vary by the type of expense. Your share is called **coinsurance** percentage.

And then

- You are responsible for any amounts above the **maximum**.

When we say “expense” in this general rule, we mean the **negotiated charge** for **in-network providers**, and **recognized charge** for **out-of-network providers**. See the *Glossary* section for what these terms mean.

Important note – when you pay all

You pay the entire expense for an **eligible dental service**:

When you get a dental care service or supply that is not **medically necessary**. See the *Medical necessity requirements* section.

In all these cases, the **dental provider** may require you to pay the entire charge. And any amount you pay will not count towards your **deductible** or towards your **Calendar Year** or **lifetime maximum**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses or costs in excess of the **negotiated charge** for **in-network covered benefits**

Where your schedule of benefits fits in

This section explains some of the terms you will find in your schedule of benefits.

How your deductible works

Your **deductible** is the amount you need to pay for **eligible dental services** per **Calendar Year** before your plan begins to pay for **eligible dental services**. Your schedule of benefits shows the **deductible** amounts for your plan.

How we count your deductible

When you see **in-network providers**, we count the **negotiated charge** toward your **in-network deductible**. When you see **out-of-network providers**, we count the **recognized charge** toward your **out-of-network deductible**.

How coinsurance works

Coinsurance is the amount your plan pays for **eligible dental services** after you have paid your **deductible**. Your schedule of benefits shows you which **coinsurance** your plan will pay for specific **eligible dental services**.

How your maximum works

The maximum is the most your plan will pay for **eligible dental services** per **Calendar Year** and lifetime incurred by you or your covered dependent after any applicable **deductible** and **coinsurance**. You are responsible for any amounts above the **maximum**.

Important note:

See the schedule of benefits for any **deductibles**, **coinsurance**, maximum and maximum age, visit limits, and other limitations that may apply.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible dental services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

Your **dental provider** is required to send us a claim in writing. You may send us a claim, at your option. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

The table below explains the claim procedures as follows:

Notice	Requirement	Deadline
Submit a claim	- You should notify us in writing within 20 days or as soon as reasonably possible after that and request a claim form from us - We will send the claim form to you within 15 calendar days of your request. If we do not provide you with a claim form within 15 days, you will have complied with any requirements to submit proof of loss. - The claim form will provide instructions on how to complete and where to send the form(s)	- You must send us notice and proof within 90 days. - If you are unable to complete a claim form, you may send us: - A description of services - Bill of charges - Any dental documentation you received from your dental provider

Proof of loss (claim) When you have received a service from an eligible dental provider , you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us	• You must send us notice and proof within 90 days
Benefit (claim) payment	• Written proof must be provided for all benefits • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits (claims) will be paid as soon as the necessary proof to support the claim is received

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 24 months after the deadline.

Communicating our claim decisions

The amount of time that we have to tell you about our decision on a claim is shown below.

Post-service claim

A post service claim is a claim that involves dental care services you have already received.

Type of notice	Post-service claim*
Initial decision by us	30 days (electronic claims) 40 days (claims received by other means)
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

*We will acknowledge receipt of an electronic claim within 2 business days following receipt of the claim. We will acknowledge receipt of a claim received by others means within 10 business days upon receipt of the claim. You can request the status of your paid or pending claim by calling Member Services at 1-877-238-6200.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **in-network provider** and the **recognized charge** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your coverage entirely.

Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **dental provider** or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An appeal

You can ask us to review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination. Or you can call Member Services at 1-877-238-6200. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **dental provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **dental provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of notice	Post-service appeal
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

Exhaustion of appeals process

You may contact the New Jersey Department of Banking and Insurance or Office of Insurance Claims Ombudsman to file a complaint based on questions you may have about your benefits described in the booklet-certificate, such as procedures that are covered or not covered, frequency limits, timely payment of **premiums** and eligibility. You are not required to exhaust the one level appeal process before contacting the New Jersey Department of Banking and Insurance or Office of Insurance Claims Ombudsman.

New Jersey Department of Banking and Insurance
Consumer Protection Services
P.O. Box 329
Trenton, New Jersey 08625-0329

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467
(outside of NJ call 609-292-5316 and ask for the Ombudsman's Office)
Fax: 609-292-2431
Email: ombudsman@dobi.nj.gov

In most situations, we encourage you to complete the one level of appeal with us before you pursue arbitration, litigation or other type of administrative proceeding.

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal.

Coordination of benefits

Some people have dental coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:

- A dental care expense that any of your dental plans cover to any degree. If the dental care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic** surgery generally is not an allowable expense under this plan.

Claim determination period means:

- A **Calendar Year**, or any part of a **Calendar Year**, during which you and your dependents are covered by this plan and at least one other plan and incurs allowable expenses under these plans.

“Plan” means:

- Coverage with which coordination of benefits is allowed. Plan includes:
 - Group insurance and group subscriber contracts, including insurance continued according to a federal or state continuation law
 - Self-funded arrangements of group or group-type coverage, including insurance continued according to a federal or state continuation law
 - Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued according to a federal or state continuation law
 - Group hospital indemnity benefit amounts that exceed \$150.00 per day
 - **Medicare** or other governmental benefits, except when, according to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan
- “Plan” does not include:
 - Individual or family insurance contracts or subscriber contracts
 - Individual or family coverage through a health maintenance organization (HMO) or under any other prepayment, group practice and individual practice plans
 - Group or group-type coverage where the cost of coverage is paid solely by the covered person coverage being continued according to a federal or state continuation law will be considered a plan
 - Group hospital indemnity benefit amounts of \$150.00 per day or less
 - School accident-type coverage
 - A state plan under Medicaid

Primary plan means:

- A plan whose benefits for your health care coverage must be determined without taking into consideration the existence of any other plan. There may be more than one primary plan. A plan will be the primary plan if either of the below exist:
 - The plan has no order of benefit determination rules, or it has rules that differ from those contained in this coordination of benefits section
 - All plans which cover you use order of benefit determination rules consistent with those contained in the coordination of benefits section and under those rules, the plan determines its benefits first.

Here's how COB works

- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are:	Primary plan	Secondary plan
Covered under the plan as an employee, retired employee or dependent	The plan covering you as an employee or retired employee	The plan covering you as a dependent
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the Calendar Year *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)* *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for dental coverage But if that parent has no coverage then the other spouse's plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse's plan is primary.

Child of: Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule	
Child of: Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: - The plan of the custodial parent pays first - The plan of the spouse of the custodial parent (if any) pays second - The plan of the noncustodial parents pays next - The plan of the spouse of the noncustodial parent (if any) pays last	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)

COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally	

How are benefits paid?	
Primary plan	The primary plan pays your claims as if there is no other dental plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist, and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense

Other dental coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly. See the *How to contact us for help* section for details.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other dental plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends.

When will your coverage end?

Coverage under this plan will end if:

- This plan is discontinued
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage
- Your employment ends
- You do not pay any required **premium**
- We end your coverage
- You become covered under another dental plan offered by your policyholder

Your coverage will end:

- On either the date your employment ends, or the day before the first **premium** contribution due date that occurs after you stop active work

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of illness, injury , sabbatical or other authorized leave as agreed to by the policyholder and us.	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: Your coverage will stop on the date that your employment ends.
Your employment ends because: - Your job has been eliminated - You have been placed on severance, or - This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the <i>Special coverage options after your plan coverage ends</i> section.
Your employment ends because of a paid or unpaid medical leave of absence	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence.
Your employment ends because of a leave of absence that is not a medical leave of absence	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: Your coverage may continue until stopped by the policyholder but not beyond 1 month from the start of the absence.
Your employment ends because of a military leave of absence.	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.

It is your policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- The **group policy** ends
- You do not pay the required **premium** toward the cost of dependents' coverage
- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners
- The date the domestic partnership ends. For domestic partnerships, you should provide the policyholder a completed and signed Declaration of Termination of Domestic Partnership.

Your dependents coverage will end:

- On the earlier of the date the **group policy** terminates or
- As defined by the policyholder.

Your dependents coverage will end on the earlier of the date the **group policy** terminates or as defined by the policyholder.

What happens to your insured dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end you and your dependent's coverage?

We will give you 60 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their dental coverage for 18, 29 or 36 months after a “qualifying event”. COBRA usually applies to policyholders of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree dental coverage and your former policyholder files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Policyholder/Group dental plan notification requirements		
Notice	Requirement	Deadline
General notice – policyholder or Aetna	Notify you and your dependents of COBRA rights	Within 90 days after active employee coverage begins
Notice of qualifying event – policyholder	- Your active employment ends for reasons other than gross misconduct - Your working hours are reduced - You become entitled to benefits under Medicare - You die - You are a retiree eligible for retiree dental coverage and your former policyholder files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – policyholder or Aetna	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA – policyholder or Aetna	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice – policyholder or Aetna	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the policyholder if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the policyholder if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify the policyholder if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify the policyholder if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
- You die - You divorce or legally separate and are no longer responsible for dependent coverage - You become entitled to benefits under Medicare - Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?

You enroll by sending in an application and paying the **premium**. Your policyholder has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% covers administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the policyholder within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group dental plan.
- You or a covered dependent become entitled to benefits under **Medicare**.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons

What exceptions are there for dental work when coverage ends?

Your dental coverage may end while you or your covered dependent are in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed partial dentures (bridges)
- Root canals

Ordered means:

- For a denture: The impressions from which the denture will be made were taken
- For a root canal: The pulp chamber was opened
- For any other item: The teeth which will serve as retainers or supports, or the teeth which are being restored:
 - Must have been fully prepared to receive the item
 - Impressions have been taken from which the item will be prepared

How can you extend dental coverage for your disabled child beyond the plan age limits?

You have the right to extend dental coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of an intellectual or physical disability, and
- Depends mainly (more than 50% of income) on you for support

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

Your disabled child's coverage will end:

- On the date the child is no longer disabled and dependent upon you for support or
- As explained in the *When will coverage end for any dependents* section

How can you extend coverage for a child in college on medical leave?

You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins, or
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness or injury**,
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as **medically necessary** due to a serious **illness or injury**

We must receive documentation or certification of the **medical necessity** for a leave of absence:

- At least 30 days prior to the absence, if the medical reason for the absence and the absence are foreseeable, or
- 30 days after the start date of the medical leave of absence from school

The **physician** treating your child will be asked to keep us informed of any changes.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to federal and state laws that apply. You and we will interpret it according to these laws.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. They are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the **group policy**. This document may have amendments too. Under certain circumstances, we or the policyholder or the law may change your plan. Only **Aetna** may waive a requirement of your plan. No other person – including the policyholder or **provider** – can do this.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund any unearned **premium**.

Out-of-network provider reimbursement

No assignment or transfer by you of any of your interest under this policy or by a covered dependent of any of his or her interest under this policy is valid unless **Aetna** consents thereto.

When you or your covered dependent submit a claim and assign the right to receive reimbursement for covered **medically necessary** services to an **out-of-network provider**, we are required to pay benefits in line with the assignment of benefits by remitting payment directly to the **dental provider** in the form of a check payable to the **dental provider**, or in the alternative, to the **dental provider** and you or your covered dependent as a joint payee, with signature lines for each of the payees.

Any payment made solely to you or your covered dependent rather than the **dental provider** under these circumstance shall be considered unpaid, and unless remitted to the **dental provider** within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in that act.

Financial sanctions exclusions:

If coverage provided under this booklet-certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible dental services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Assets Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Legal action

We encourage you to complete the appeal process before you take any legal action against us for any expense or bill. You cannot take any action until 60 days after we receive written submission of claim. See the *When you disagree - claim decisions and appeals procedures* section.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations

At our expense, we have the right to have a **provider** of our choice examine you. This will be done at all reasonable times while a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **dental providers, dentists** and other **providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception**Honest mistakes**

You or your policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 60 days advanced written notice of any rescission of coverage.
- You have the right to an **Aetna** appeal.

Some other money issues

Assignment of benefits

When you see a **provider** they will bill us directly. You may send us a claim, at your option. When you see **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** under this **group policy**. This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this **group policy**

To request assignment you must complete an assignment form. The assignment form is available from the policyholder. The completed form must be sent to us for consent.

Recovery of overpayments

We sometimes pay too much for **eligible dental services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **provider** – to return what we paid. If we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

We will not request reimbursement for an overpayment, except in the case of fraud or a pattern of inappropriate billing or claims later than 18 months after the date of the first payment on the claim. We will not pursue more than one reimbursement for overpayment of a particular claim.

Premium

This plan requires the policyholder to pay **premium** payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** payments are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Payment of premiums

The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium due date**"). Each **premium** payment is to be paid to us on or before the **premium due date**.

Your dental information

We will protect your dental information. We will use it and share it with others to help us process your **providers'** claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call Member Services at 1-877-238-6200. When you accept coverage under this plan, you agree to let your **providers** share your information with us. We will need information about your physical and mental condition and care.

Effect of benefits under other plans

Effect of prior coverage - transferred business

Prior coverage means:

- Any plan of group coverage that has been replaced by coverage under part or all of this plan.
- The plan must have been sponsored by the policyholder (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage any benefits provided under such prior coverage may reduce benefits payable under this plan. See the *General coverage provisions* section of the schedule of benefits.

Dental coverage under this plan will continue uninterrupted for your dependent college student who takes a **medically necessary** leave of absence from school. See the *Special coverage options after your plan coverage ends* section.

Glossary

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

Calendar year

A period of 12 month beginning on January 1st and ending on December 31st.

Calendar year maximum

This is the most this plan will pay for **eligible dental services** incurred by you during the **calendar year**.

Coinsurance

The specific percentage we have to pay for a dental care service.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits

Eligible dental services that meet the requirements for coverage under the terms of this plan.

Deductible

The amount you pay for **eligible dental services** per **calendar year** before your plan starts to pay.

Dental emergency

Any dental condition that:

- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition, and
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services

Services and supplies given by a **dental provider** to treat a **dental emergency**.

Dental provider

Any individual legally qualified to provide dental services or supplies.

Dentist

A legally qualified **dentist** licensed to do the dental work he or she performs.

Directory

The list of **in-network providers** for your plan. The most up-to-date **directory** for your plan appears at www.aetna.com, or you can call us at 1-877-238-6200 for assistance. When searching, you need to make sure that you are searching for **providers** that participate in your specific plan. **In-network providers** may only be considered **in-network providers** for certain Aetna plans.

Effective date of coverage

The date you and your dependent's coverage begins under this booklet-certificate as noted in our records.

Eligible dental services

The dental care services and supplies listed in the schedule of benefits and not listed or limited in the *What rules and limits apply to dental care?* and *What your plan doesn't cover – some eligible dental service exceptions and exclusions* sections of this plan.

Experimental or investigational

A drug, device, procedure, or treatment that we find is **experimental or investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness or injury** involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.
- It is provided or performed in a special setting for research purposes.

Group policy

The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any amendments to the **group policy**, the booklet-certificate, and the schedule of benefits

Illness

Poor health resulting from disease of the teeth or gums.

Injury or injuries

Physical damage done to the teeth or gums.

In-network provider

A **provider** listed in the **directory** for your plan.

Medicare

As used in this plan, **Medicare** means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare**.

Medically necessary/medical necessity

Dental care services that we determine a **provider** using sensible clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury, disease** or its symptoms, and that we determine are:

- In accordance with generally accepted standards of dental practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **dentist**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce the same benefit or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease

Generally accepted standards of dental practice means standards based on credible scientific evidence published in peer-reviewed dental literature and is:

- Generally recognized by the relevant dental community
- Consistent with the standards set forth in policy issues involving clinical judgment

Negotiated charge

This is either:

- The amount **in-network providers** have agreed to accept
- The amount we agree to pay directly to **in-network providers** or third party vendor (including any administrative fee in the amount paid)

for providing **eligible dental services** to covered persons in the plan.

Orthodontic treatment

This is any:

- Medical service or supply
- Dental service or supply

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth
- Of the bite
- Of the jaws or jaw joint relationship

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer
- A surgical procedure to correct malocclusion

Orthodontic treatment lifetime maximum

The most the plan will pay for **eligible dental services** for **orthodontic treatment** that you incur during your lifetime is called the **orthodontic treatment lifetime maximum**.

Out-of-network provider

A **provider** who is not an **in-network provider** and does not appear in the **directory** for your plan.

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Premium

The amount you or the policyholder are required to pay to **Aetna** to continue coverage.

Provider

A **dentist**, or other entity or person licensed, or certified under applicable state and federal law to provide dental care services to you.

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge**. The **recognized charge** may be less than the **provider's** full charge.

Your plan's **recognized charge** applies to all out-of-network **eligible dental services**. In all cases, the **recognized charge** is based on the geographic area where you receive the service or supply.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider bills**

and:

- 90% of the **prevailing charge rate**

The **recognized charge** for **providers** in the dental out-of-network savings program is the lesser of what the **provider bills** and the agreed upon rate for **providers**, with whom we have a contract through any third party that is not an affiliate of **Aetna**.

Your out-of-network cost sharing applies when you get care from dental out-of-network savings program **providers** except for **dental emergency services**.

Special terms used:

Geographic area

The geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Prevailing charge rate:

The 90th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute an alternative database that we believe is comparable.

Additional information:

Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool to help decide whether to get care in-network or out-of-network. Aetna's secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to access the "Estimate the Cost of Care" feature. Within this feature, view our "Dental Cost of Care" tool. You may also contact Member Services at 1-877-238-6200.

Temporomandibular joint dysfunction/disorder

This is:

- A **temporomandibular joint (TMJ) dysfunction/disorder** or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Aetna Life Insurance Company



New Jersey Life And Health Insurance Guaranty Association Act

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center
9th Floor
Newark, NJ 07102

State of New Jersey
Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

Coverage

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health insurance or long-term care insurance contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons owning such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy was issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

Limitations of Coverage

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than \$500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than \$100,000 in cash surrender values for annuity benefits, \$500,000 in life insurance death benefits or \$500,000 in present value of annuities--again no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

The Association will not pay more than \$2,000,000 in benefits to any one contract holder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

Aetna Life Insurance Company

Group policy

The **group policy** is by and between

Aetna Life Insurance Company

(Aetna, we, us, or our)

and

Monroe Township Board of Education

(**Policyholder**, you, or your)

Group policy number: 152709

Date of issue: June 25, 2020

Effective date: July 1, 2020

Renewal date: July 1, 2021

Policyholder situs: New Jersey

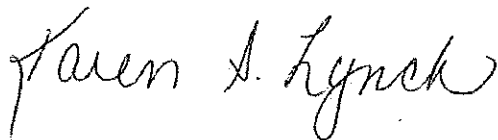
This **group policy** takes effect on the **effective date** if we have received your signed group application and the initial **premium**. It remains in force until terminated.

Term of the group policy: The initial term shall be the 12 consecutive months period beginning on the **effective date**.
Subsequent terms shall be the 12 consecutive months period beginning with the **renewal date**.

Premium due dates: The **effective date** and the first day of each succeeding calendar month.

Signed at Aetna's Home Office 151 Farmington Avenue Hartford, Connecticut 06156.

This **group policy** is non-participating. This means **Aetna** does not pay dividends to **policyholders**.
This **group policy** is governed by applicable federal law and the laws of New Jersey.



Karen S. Lynch

President

Aetna Life Insurance Company

(A Stock Company)

Table of contents

	Page
The group policy	1
If you want to discuss your coverage	1
Glossary.....	2
Premium.....	3
Fees for special services	5
Some of our other responsibilities	6
Some of your other requirements and responsibilities	7
Termination.....	9
Intentional deception.....	11
Responsibility for conduct.....	12
General provisions	13
Final rates schedule	18

The group policy

The **group policy** consists of several documents taken together. These documents are:

- Your group application
- This **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any riders and amendments to the **group policy**, the booklet-certificate, and the schedule of benefits as stated below.

All policy attachments and booklet-certificate documents that are part of the complete policy are on file with the **policyholder** and us.

If you want to discuss your coverage

If you have questions about your coverage under the **group policy**, or if you wish to discuss it, contact your agent. If you did not use an agent to purchase your coverage, or if you have additional questions, you may contact us at:

Aetna
151 Farmington Avenue
Hartford, Connecticut 06156
1-877-238-6200

Please have your **group policy** number available when you contact us. It is on the front page of this **group policy**.

Glossary

You will see some words in bold type in the **group policy**. The bold type means we have defined those words.

Covered person

An employee or a dependent of an employee for whom all of the following applies:

- The person is eligible for coverage as defined in the booklet-certificate.
- The person has enrolled for coverage and paid any required **premium** contribution.
- The person's coverage has not ended.

Dates:

Effective date

Date we first cover you under the **group policy**.

Final rates schedule effective date

Date stated on the final rates schedule.

Premium due date

The **effective date** and the 1st day of each succeeding calendar month.

Renewal date

Date that is 12 months after the **effective date** and each 12 month date thereafter.

Termination date

The date coverage ends according to the *Termination* section.

Policyholder

Monroe Township Board of Education and entities associated with it for purpose of coverage under this **group policy**.

Premium

Premium – rates and amount due

The **premium** rates are stated in the *Final rates schedule* section. You will receive a new *Final rates schedule* if and when the **premium** rates change. Any new schedule will state its **effective date**.

We charge **premium** based on the **premium** rates in effect on the **premium due date**. The **premium** due on any **premium due date** is the total of the **premium** charges for your coverage. When we calculate **premium** due, we will use our records to determine who is a **covered person**.

You owe **premium** for a **covered person** starting with the first **premium due date** on or after the day the person's coverage starts. You stop paying **premium** for a **covered person** as of the first **premium due date** on or after the day the person's coverage ends.

Premium – changes in rates

We may change the **premium** rates as of a **premium due date** during the initial term only if:

- There is a change in factors that materially affects the risk we assumed with this coverage. We will explain these changes in factors in our rate quote to you.
- There is a change in law or regulation, or there is a judicial decision, that materially affects the cost of providing coverage.

We may change the **premium** rates as of a **premium due date** during any following term.

We will let you know in writing of any change in premium rates 60 days before they take effect.

Premium – when due

Premium is due on the **premium due date**. You have a payment grace period of 31 days immediately following the **premium due date**. The **group policy** will remain in force during the grace period. If we have not received all **premiums** due by the end of the grace period, this **group policy** will automatically terminate at the end of the grace period. Refer to the *Termination* section of the **group policy**.

Premium – how billed and paid

We may bill you electronically. You shall pay **premium** due by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

We may choose not to accept **premium** that is paid for the **policyholder** by someone else unless we are required to by law.

Premium – overdue amounts

If you don't pay your premium on time, we will charge you interest on the total **premium** amount that is overdue. Overdue **premium** includes amounts due but not yet paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

We may also recover from you the costs of collecting any unpaid **premium**, including reasonable attorney fees and costs of suit.

Premium – eligibility corrections

We will retroactively drop a **covered person** from coverage and credit you **premium** payments if:

- The eligibility information included a person who was not eligible for coverage
- You request that we retroactively drop the person from coverage

If you ask us to retroactively drop coverage, we will consider that as your statement that the person did not pay the required **premium** contribution for the period.

We will retroactively cover eligible persons who were not included in the eligibility information you provided us. We will cover them retroactively no more than 60 days before the date you both notify us and pay all applicable past **premium**.

Premium – waiver

Payment of premiums

We may waive up to one month's billed **premium** payments during any **group policy** term.

The **premium** waiver will not apply for those employees who were added or removed from the plan after we billed you for that month's premium. For that month of coverage, additional **premium** will be due or credited.

Repayment of the waived premium

We may require you to pay back the **premium** waived if the **group policy** is terminated within 12 months of your original **effective date**. We will give at least 60 days prior written notice to you of the requirement for the repayment of the waived **premium**.

Fees for special services

Special services

You may request that we provide special services beyond the routine administration of this **group policy**. We will charge you a fee for each special service.

Special services – fees

The *Final rates schedule* lists the special service fees. We may change any fee on 60 days advance written notice to you. We will provide you with a new *Final rates schedule* if the amount of any fee changes. The new schedule will state its **effective date**.

Fees– when due

Fees are due on the **premium due date** immediately following our invoicing you.

Fees– how billed and paid

We may bill you electronically. You shall pay fees by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Fees– overdue amounts

You shall pay us interest on the total amount of fees that is overdue. Overdue fees include amounts due but not paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

We may also recover from you the costs of collecting any unpaid fees, including reasonable attorney fees and costs of suit.

Some of our other responsibilities

We will prepare the booklet-certificate and schedule of benefits that are part of the **group policy**, as required by applicable federal and state laws. We will provide them to you in electronic form. We will also provide them to you in paper form if you request it.

We will provide the coverage stated in the booklet-certificate and schedule of benefits that are part of the **group policy**. We will administer the coverage as required by the **group policy** and applicable federal and state laws.

We will protect the personal health information of **covered persons** as required by federal and state laws. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help us process **providers'** claims and otherwise help us administer the **group policy**. For a copy of our Notice of Privacy Practices, call Member Services at 1-877-238-6200 or log on to www.aetna.com.

Our duties in this section survive termination of the **group policy**.

Some of your other requirements and responsibilities

Participation and contribution

You must comply with our participation and contribution requirements.

Distribution – booklet-certificate and schedule of benefits

You will distribute as required by applicable federal and state laws, the booklet-certificate and schedule of benefits that we provide you.

Information – access

You shall make payroll and other records directly related to a person's coverage under this **group policy** available to us for inspection. This will occur:

- Upon our reasonable advance request
- At our expense
- At your office
- During regular business hours

Your duties and our rights in the Information – access provision survive termination of the **group policy**.

Information – eligibility

You shall send us eligibility information we request to administer the **group policy**. We will request the information monthly or as otherwise required. You will send us the information on our form, or through such other means, as we require.

The eligibility information includes but is not limited to data needed to:

- Enroll your employees and their dependents
- Process terminations
- Make changes in family status

By sending the information to us, you represent that it is correct. You acknowledge that we can and will rely on the information.

You shall:

- Maintain a reasonably complete record of the information you send us for at least seven years, and until the final rights and duties under the **group policy** have been resolved
- Send us information you sent us before, upon request

We will not start covering a person under the **group policy** until you send us the information to enroll that person. Subject to applicable federal and state laws and the **group policy**, we will not stop covering a person until you send us the information to terminate coverage.

You shall notify us within 15 business days of the date in which:

- An employee's employment ceases, or
- A dependent loses eligibility under the **group policy**

You must notify us when a request for retroactive termination is a result of a **covered person**:

- Performing an act or omission that constitutes fraud, or
- Making an intentional misrepresentation of material fact to get coverage or to get a benefit under the **group policy**.

Your duties and our rights in this Information – eligibility provision survive termination of the **group policy**.

Notices – termination of coverage

You shall notify **covered persons** in writing, of their rights when coverage stops.

In particular, you shall notify all eligible **covered persons** of their right to continue coverage pursuant to the *Special coverage options after your plan coverage ends* provisions in the booklet-certificate and applicable federal and state laws. Your notification will include:

- A description of plans available
- **Premium** rates
- Application forms

You will give the notification within 15 calendar days of a person becoming eligible for continuation coverage.

Your duties and our rights in this provision survive termination of the **group policy**.

Workers' compensation coverage

You must comply with workers' compensation coverage laws applicable to your employees covered by the **group policy**. Prior to the **effective date** and upon our request after the **effective date** you will provide us reasonable evidence of your satisfying applicable workers compensation coverage laws.

You will provide us with monthly reports of all workers' compensation coverage cases. The report will list for each case, the employee name, identifying number, date of loss and diagnosis.

Termination

Automatic termination

The **group policy** and all coverage end as of the last day of the grace period if you have not paid us all **premiums** due as of the beginning of the grace period. The *Premium* section has a description of the grace period.

Termination by you

You may end coverage under this **group policy** if you give us 30 days advance written notice. Your termination notice may apply to all classes or any class of your employees covered under the **group policy**. You can send us a termination notice during a period for which you have paid **premium**, but your **termination date** must be after that period.

Termination by us

We may end the **group policy** and all coverage it provides:

- We will give you 60 days advance written notice before we end your coverage. The notice will state the **effective date** of rescission:
 - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage
 - If you are a member of an association and your membership in the association ceases
- Upon 60 days written notice to you:
 - If you breach a provision of the **group policy** and you do not cure the breach within the notice period
 - If you cease to be a group as defined under applicable state law
 - If you fail to meet our contribution or participation requirements applicable to this **group policy**
 - If you do not certify your compliance with our policies and procedures upon request
 - If you change your eligibility or participation requirements without our consent
- Upon 60 days written notice to you (or such longer notice period as applicable federal and state laws require,) if we cease to offer the product line provided by this **group policy**.
- Upon 60 days written notice to you (or such longer notice period as applicable federal and state laws require,) if we act as required by applicable federal and state laws for uniform termination of coverage.

Non-renewal for failure to respond

We may request that you tell us whether you intend to renew the **group policy**. You must reply:

- Within two weeks of your receipt of the request
- Within 15 days prior to the **renewal date**

whichever is later.

Your reply must be in writing unless we authorize an oral reply. If you do not reply, we will continue coverage on and after the **renewal date** and:

- You owe us any unpaid premium
- We owe you a refund if you overpaid premium

Effective time of termination

The **group policy** and its coverage end at 11:59 p.m. on the day of termination.

Effect of termination

You, **covered persons**, and we continue to be responsible following termination for the duties we each incur prior to the termination of the **group policy**. One of your duties includes payment of **premium** due for coverage through any grace period up to the day of termination. You, **covered persons**, and we also continue to be responsible for your, their, and our duties that the **group policy** states are to occur following termination.

You, **covered persons**, and we have the rights and duties following termination of the **group policy**, as stated specifically in the **group policy**.

You shall notify **covered persons** of the termination of the **group policy**. Your notice will comply with applicable federal and state laws. We have the right to notify employees of termination of the **group policy**.

Reinstatement

You may request that we reinstate the **group policy** and coverage after we end it. You must make the request within 30 days of the **termination date**. We will reinstate the **group policy** as of the **termination date** upon payment of all amounts due, and you giving us reasonable assurances that you can, and will fulfill, all of your obligations under the **group policy**.

Intentional deception

If we learn that you or a **covered person** defrauded us or that a **covered person** intentionally misrepresented material facts, we can and may take actions that can have serious consequences for coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward
- Denial or termination of benefits
- Recovery of amounts we already paid

We also may report fraud to law enforcement.

Rescission means you or a **covered person** loses coverage both going forward and going backward. If we paid claims for past coverage, we are entitled to receive the money back.

A **covered person** has special rights if we rescind coverage just for that individual:

- We will give the **covered person** 60 days advance written notice of any rescission of coverage.
- The **covered person** has the right to an **Aetna** appeal.

Responsibility for conduct

Employees and agents

We are responsible to you for what our employees and other agents do.

We are not responsible to you for what is done by others, such as **providers**. They are not our employees or agents. **Providers** in our network are what the law calls our independent contractors. That simply means we have a business relationship with them and they are not our employees or agents.

Indemnification – in general

We agree to indemnify and hold you harmless against that portion of your liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by our willful misconduct, criminal conduct or material breach of this **group policy**.

You agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your:

- Negligence
- Breach of the **group policy**
- Breach of applicable federal and state laws
- Willful misconduct
- Criminal conduct
- Fraud
- Breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this **group policy** or your role as employer or Plan Sponsor, as defined by ERISA

These indemnification obligations end with the **group policy**, except as to any matter concerning a claim that has been made in writing within 365 days after termination.

General provisions – content and interpretation of the group policy

Applicable law

Applicable law means all federal and state laws that apply to the matters covered by the **group policy**. Federal and state law means statutes, regulations, official agency direction and guidance, and judicial decisions and orders, as they may be passed or issued, or as they may be amended, from time to time.

Compliance with law

You and we shall interpret the **group policy** if possible so it complies with applicable federal and state laws.

If the **group policy** omits or misstates any right or duty under applicable federal and state laws, you and we shall implement the **group policy** as though the right or duty is stated correctly in the **group policy**.

If any provision of the **group policy** is invalid or illegal, you and we shall implement the **group policy** as though the provision is not in the **group policy**.

Changes to the group policy

The **group policy** may be amended by a writing to which we both consent.

We may change or end some or all coverage under this **group policy** by notice, if we act as required by applicable federal and state laws for uniform modification of coverage and uniform termination of coverage.

We may amend the **group policy** by notice. We must give you 60 days advance written notice. Our amendment:

- Will not reduce benefits or coverage
- Will not eliminate benefits or coverage
- Will not increase benefits or coverage with a concurrent increase in **premium** during the current **group policy** term, other than increased benefits or coverage required by law.

Payment of the applicable **premium** on the **effective date** of any amendment is your consent to any amendment requiring your consent.

Changes to the **group policy** do not require the consent of any employee or of any other person. All agreements made by us are signed by an authorized executive officer of **Aetna**. Only an authorized officer of **Aetna** may change or waive any of the policy terms or make any agreement binding us.

The **group policy** shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations. You will not have to give written policy of a change in the **group policy** if:

- You asked for the change and we have agreed to it.
- The change is needed to correct an error in the **group policy**, including any booklet-certificate issued to anyone.
- The change is needed so that the **group policy** will conform to any law, regulation or ruling of a jurisdiction that affects a person covered under this **group policy**; or the Federal Government.
- We initiated the change and this change will not result in either a reduction or elimination in benefits or coverage or an increase in **premium**.

You will have to give written **policy** of a change in the **group policy**:

- That reduces or eliminates benefits or coverage
- That increases benefits or coverage with a concurrent increase in **premium** during the policy term, except if the increased benefits or coverage is required by law.

Payment of the applicable **premium** after notice of the proposed changes will be deemed to constitute your written **policy** of those changes on behalf of all persons covered under this **group policy**.

Entire group policy

The **group policy** replaces and supersedes:

- All other prior group policies of dental coverage between us
- Any other prior written or oral understandings, negotiations, discussions or arrangements between us related to this dental coverage

Waiver

Only an officer of **Aetna** may waive a requirement of the **group policy**.

We may fail to implement or fail to insist upon compliance with a provision of the **group policy** at any given time or times. Our failure to implement or to insist on compliance is not a waiver of our right to implement or insist upon compliance with that provision at any other time or times.

General provisions – administration of the group policy

Aetna name, symbols, trademarks and service marks

We control the use of our name and of our symbols, trademarks and service marks presently existing or subsequently established. You shall not use any of them in advertising or promotional materials or in any other way without our prior written consent. You shall stop any and all use immediately upon our direction or upon termination of the **group policy**.

Assignment and delegation

You shall not assign any right or delegate any duty under the **group policy** unless we approve it in writing in advance.

We may delegate some of our functions under the **group policy** to third parties. We may also change or end these delegations. We do not need to give you advance notice to enter into, change or end these arrangements, and we do not need your consent.

Claim determinations (Applies to government or church plans and other plans not subject to ERISA)

We have with complete authority to review all denied claims for benefits under this **group policy**:

- To determine whether and to what extent **covered persons** are entitled to benefits
- To construe any disputed or doubtful terms under the **group policy**. We shall be deemed to have properly exercised our authority unless we abuse our discretion by acting arbitrarily and capriciously.

Our review of claims for benefits may include the use of software and other tools to take into account factors such as:

- An individual's claim history
- A **provider's** billing patterns
- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

Correcting our administrative errors

A clerical error in keeping records or a delay in making an entry will not alone determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in **premium** if correction of the error or delay changes coverage.

We may correct, withdraw, or replace the **group policy**, any booklet-certificate, any schedule of benefits and any other document issued with an error or issued in error.

Correcting your honest mistakes

If you or any employee make an honest mistake of fact, we may make a fair change in **premium**. If the misstatement affects the existence or amount of coverage, we will use the true facts to determine whether coverage is or remains in effect and its amount.

Discrimination prohibited

You shall not encourage or discourage enrollment in the coverage provided by the **group policy** based on health status or health risk.

You shall act so as not to discriminate unfairly between persons in like situations at the time of the action.

Financial Sanctions Exclusions

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, we cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit <https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Incontestability

We will not use a statement you make to void this **group policy** after it has been in force for 2 years from its **effective date**.

We will use only a statement in writing that you or a **covered person** makes, to do any of the following:

- To void coverage of the **covered person**
- To deny coverage of the **covered person**
- To deny a claim for benefits by the **covered person**

We will not use a statement by a **covered person** to deny a claim for benefit more than 2 years after the statement was made.

Notices

The **group policy** requires or permits notice to each other. These notices shall be in writing.

Notice may be delivered:

- In person, and is effective upon delivery
- By United States mail, sent first class, postage prepaid, and is effective three U.S. Postal Service delivery days following the date of mailing
- By commercial carriers UPS and FedEx, effective upon delivery
- By e-mail, facsimile or other electronic means, effective upon sending

Notice sent to us by mail and commercial carrier shall be sent to:

Aetna

151 Farmington Avenue
Hartford, Connecticut 06156

Notice sent to you by mail and commercial carrier shall be sent to:

Name of **policyholder** – Monroe Township Board of Education
Attention: Michael Gorski - Business Admin/Board Secretary
423 Buckelew Avenue
Monroe Township, NJ 08831

You and we must designate specific e-mail addresses, facsimile numbers or other electronic means in writing for purpose of notices.

Policies and procedures

We have the right to adopt reasonable policies, procedures, and rules of the **group policy** in order to promote orderly and efficient administration. You and all **covered persons** are bound by and shall comply with them. You will certify your compliance with them upon our request or as required specifically by the **group policy**.

Third parties rights

This **group policy** does not give any rights or impose any duties on third parties except as specifically stated.

Final rates schedule

The monthly premium rates are:

Dental expense coverage	
Single	\$36.35
Parent and child	\$108.84
Parent and children	\$108.84
Couple	\$108.84



**Preferred Provider Organization (PPO)
Dental Expense Insurance Plan**

Schedule of benefits

Prepared exclusively for:

Policyholder: Monroe Township Board of Education

Policyholder number: 152709
Schedule of Benefits 1A

Group policy effective date: July 1, 2020

Plan effective date: July 1, 2020

Plan issue date: June 25, 2020

Underwritten by Aetna Life Insurance Company in the state of New Jersey

Schedule of benefits

This schedule of benefits lists the **eligible dental services, deductibles, coinsurance, maximums, and other limits** that apply to the services you get under this plan.

How to read your schedule of benefits

- When we say:
 - “In-network coverage” we mean that you get care from **network providers**.
 - “Out-of-network coverage” we mean that you can get care from **out-of-network providers**.
- The **deductibles** and **coinsurance** listed in the schedule of benefits below reflects the **deductibles** and **coinsurance** amounts under your plan.
- You must pay any **deductibles** and your part of the **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You must pay the full amount of any dental care services you get that are not a **covered benefit** or that exceed your **Calendar Year** or **lifetime maximum**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. They may be combined limits between or separate maximums for **network providers** and **out-of-network providers** unless we state otherwise.

Important note:

All **covered benefits** are subject to a **Calendar Year deductible** and **coinsurance** unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer your questions.

- Log onto your secure member website at www.aetna.com.
- Call Member Services at 1-877-238-6200.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

General coverage provisions

This section explains the:

- **Deductibles**
- **Coinsurance**
- **Maximums**

Calendar Year deductible

Eligible dental services applied to the out-of-network **deductibles** will be applied to satisfy the network **deductibles**. **Eligible dental services** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

Individual deductible

This is the amount you pay for in-network and out-of-network **eligible dental services** each **Calendar Year** before the plan begins to pay. This individual **Calendar Year deductible** applies separately to you and each of your covered dependents. Once you have reached the **Calendar Year deductible**, this plan will begin to pay for **eligible dental services** for the rest of the **Calendar Year**.

Family deductible

When you and each of your covered dependents incur **eligible dental services** that apply towards the individual **Calendar Year deductibles**, these expenses will also count toward a family **deductible**.

To satisfy this family **deductible** for the rest of the **Calendar Year**, the following must happen:

- The combined **eligible dental services** that you and each of your covered dependents incur towards the individual **Calendar Year deductibles** must reach this family **deductible** in a **Calendar Year**.

When this happens in a **Calendar Year**, the individual **Calendar Year deductibles** for you and your covered dependents are met for the rest of the **Calendar Year**.

Coinsurance

Once any applicable **deductibles** have been met, the specific **coinsurance** percentage the plan pays for **eligible dental services** is listed below.

Calendar Year maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person in a **Calendar Year** is called the **Calendar Year maximum**.

The **Calendar Year maximum** applies to in-network and out-of-network **eligible dental services** combined.

Orthodontic lifetime maximum

The most the plan will pay for orthodontic expenses incurred by any one covered person during their lifetime is called the **orthodontic lifetime maximum**.

The **orthodontic lifetime maximum** applies to covered in-network and out-of-network **eligible orthodontic treatment** combined.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one **Calendar Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan features

Calendar Year deductible

You have to meet your **Calendar Year deductible** before this plan pays for benefits.

	In-network coverage	Out-of-network coverage
Calendar Year deductible	Individual \$50 Family \$100	Individual \$50 Family \$100
The Calendar Year deductible applies to all eligible dental services except Type A expenses.		

Coinsurance

The **coinsurance** listed below reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.

	In-network coverage	Out-of-network coverage
Type A expenses	80% of the negotiated charge	80% of the recognized charge
Type B expenses	80% of the negotiated charge	80% of the recognized charge
Type C expenses	50% of the negotiated charge	50% of the recognized charge

Orthodontic treatment coinsurance

	In-network coverage	Out-of-network coverage
Orthodontic treatment coinsurance	50% of the negotiated charge	50% of the recognized charge

Calendar Year maximum

	In-network coverage	Out-of-network coverage
Calendar Year maximum	\$2,000	\$2,000

Orthodontic lifetime maximum

	In-network coverage	Out-of-network coverage
Orthodontic lifetime maximum	\$1,000	\$1,000

Eligible dental services

Type A expenses: Diagnostic & preventive care

Visits and exams

- Office visit during regular office hours for oral examination, (2 visits per year or 2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning), (3 treatments per year)
- Topical application of fluoride if you are under age 19, (2 applications per year)
- Sealants, per tooth (2 applications every year for permanent molars only and if you are under age 16)
- Sealant repair - per tooth (for permanent molars only and if you are under age 16)

Space maintainers - Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removal

Images and pathology

- Bitewing images (2 sets per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 set every 3 years)
- Periapical images

Type B expenses: Basic restorative care

Visits and exams

- Office visit after hours (we will pay either for the office visit charge or for the **eligible dental services** performed, whichever is more)
- Emergency palliative treatment, per visit

Images and pathology

- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

Restorative - Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Protective restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Interim therapeutic restoration – primary dentition
- Pin retention, per tooth, in addition to restoration
- Prefabricated crowns (excluding temporary crowns)
- Recementation
- Crowns
- Repairs, full and partial denture
- Adding teeth and clasps to existing partial denture
- Inlays

- Onlays
- Labial veneers
- Repairs - inlay, onlay, veneer, crown
- Core Build Up

Oral surgery

- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth - Soft tissue
- Removal of impacted tooth - Partially bony
- Removal of impacted tooth - Completely bony
- Surgical removal of residual tooth roots
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Coronectomy

Periodontics

- Periodontal maintenance (following active therapy, 2 per year)
- Occlusal adjustment, (other than with an appliance or by restoration)
- Root planing and scaling, 1 to 3 teeth per quadrant, (1 per site per year)
- Root planing and scaling, 4 or more teeth per quadrant, (4 separate quadrants per year)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating **dentist** or their staff)
- Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant
- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant
- Soft tissue graft procedures
- Clinical crown lengthening, hard tissue
- Full Mouth Debridement, 1 per lifetime
- Guided Tissue Regeneration

Endodontics

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment
 - Anterior
 - Bicuspid
 - Molar
- Pulpal regeneration
- Periradicular surgery without apicoectomy
- Hemisection
- Retrograde filling
- Root amputation

General anesthesia and intravenous sedation

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

Type C expenses: Major restorative care

Restorative – Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic **injury**, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 5 years. (See the *Replacement rule*.)

- Post and core

Prosthodontics - The first installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 5 years old. Replacement of existing bridges or dentures is limited to 1 every 5 years. (See the *Replacement rule*.)

- Bridge abutments
- Pontics
- Dentures and partials (fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible).
 - Complete upper and lower denture
 - Partial upper and lower (including any conventional clasps, rests and teeth)
 - Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
- Special tissue conditioning, per denture
- Adjustment to denture more than 6 months after installation
- Repairs, bridges
- Occlusal guard for bruxism (1 every 3 years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance
- Implants

Type: Orthodontics care expenses

- Interceptive **orthodontic treatment**
- Limited **orthodontic treatment**
- Comprehensive **orthodontic treatment** of adolescent dentition
- Comprehensive **orthodontic treatment** of adult dentition
- Appliance therapy to control harmful habits
- Orthodontic retention
- Repair of orthodontic appliance

Additional eligible dental services

We will provide additional **eligible dental services** if you and your covered dependent have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

Additional eligible dental services:

- Prophylaxis (cleaning) (one additional per **Calendar Year**)
- Scaling and root planing, (4 or more teeth), per quadrant (one additional per **Calendar Year**)
- Scaling and root planing (limited to 1-3 teeth), per quadrant (one additional per **Calendar Year**)
- Full mouth debridement (one additional per **Calendar Year**)
- Periodontal maintenance (one additional per **Calendar Year**)

Payment of benefits

We will waive the **Calendar Year deductible** for the additional **eligible dental services** above. The **coinsurance** applied to the additional **eligible dental services** will be 100% for in-network coverage and 100% for out-of-network coverage. These additional benefits will not be subject to any frequency limits except as shown above, or to any **Calendar Year** maximum.



151 Farmington Ave
Hartford, CT, 06156

Date: May 28, 2021

We make it easy for you to make informed health care decisions

Dear Aetna Member:

You'll find your Summary of Coverage/Schedule of Benefits and your booklet on your secure member website. These documents have the details of your health care benefits. You'll also learn about your share of the costs and which services are covered.

Just log in to your secure member website on www.aetna.com. And select "Coverage & Benefits."

We provide free aids and services to people with disabilities to help them communicate effectively with us. If you need these services, just contact the number on your ID card.

What happens if I change plans or coverage?

You can always rely on your secure member website to display the most up-to-date versions of the Summary of Coverage/Schedule of Benefits and your booklet.

If you don't have access to the Internet or would prefer a paper copy, please contact your employer's benefits office.

Sincerely,
Aetna

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).



151 Farmington Ave
Hartford, CT, 06156

Date: May 28, 2021

Re: Monroe Township Board of Education

We're sending you an electronic file with your plan documents

Thank you for doing business with Aetna. Enclosed are your plan documents. Here are a couple of other things to keep in mind as you review this material.

For your employees

Members can find their benefit information on their secure member website. They can go to **Aetna.com** to log in or sign up.

For people with disabilities

We offer free aids and services to people with disabilities to help them communicate with us. If a member needs these services, have them call the number on their ID card.

Addendum Tagline – Basic Vision

Addendum Tagline - Medical

Member Letter

Booklet Certificate 1: Basic Vision
Schedule of Benefits 1A: Basic Vision

Booklet Certificate 1: Open Access Elect Choice Plan
Schedule of Benefits 1A: Open Access Elect Choice Plan

Booklet Certificate 2: Open Access Managed Choice Plan
Schedule of Benefits 2A: Open Access Managed Choice \$10 Plan
Schedule of Benefits 2B: Open Access Managed Choice \$20 Plan

Booklet Certificate 3: Open Access Managed Choice – New Jersey Educator Health Plan
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Schedule of Benefits 3A: Open Access Managed Choice – New Jersey Educator Health Plan

Amendment 5: Infertility benefit

Amendment 6: Open Access Elect Choice - Ostomy benefit

Amendment 7: Open Access Managed Choice \$10 Plan - Ostomy Benefit

Amendment 8: Open Access Managed Choice \$20 Plan - Ostomy Benefit

When reviewing your plan documents

When you use these documents, you agree not to change their content in any way without our consent. By using these letters you also agree to indemnify and hold us harmless for all loss, liability, damage, expense, cost or other obligation we may incur or be required to pay as a result of any claim, demand or lawsuit brought by any party (including yourself) arising from or in connection with any unauthorized changes.

If you have any questions, please contact your account manager.

Sincerely,
Aetna

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

BENEFIT PLAN

**Prepared Exclusively For
Monroe Township Board of Education**

**Open Access Managed Choice - New Jersey
Educator Health Plan**

**What Your Plan
Covers and How
Benefits are Paid**

**Aetna Life Insurance Company
Booklet-Certificate**

This Booklet-Certificate is part of the Group Insurance Policy
between **Aetna** Life Insurance Company and the
Policyholder





Preferred Provider Organization (PPO) Medical Plan

Booklet-certificate

Prepared exclusively for:

Policyholder:	Monroe Township Board of Education
Group policy number:	GP-152709
	Booklet-certificate 3
Policyholder situs	New Jersey
Group policy effective date:	July 1, 2020
Plan effective date:	January 1, 2021
Plan issue date:	May 28, 2021
Plan revision effective date:	July 1, 2021

This Certificate is not in place of insurance for Worker's Compensation. This certificate is governed by applicable federal law and the laws of New Jersey.

Underwritten by Aetna Life Insurance Company

Welcome

Thank you for choosing **Aetna**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan for in-network and out-of-network coverage.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become insured, this booklet-certificate becomes your certificate of coverage under the group policy, and it takes the place of all certificates describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the group policy between **Aetna Life Insurance Company** (“**Aetna**”) and the policyholder. Ask the policyholder if you have any questions about the group policy.

Oh, and each of these documents may have amendments attached to them. They change or add to the documents they’re part of.

Where to next? Flip through the table of contents or try the *Let’s get started!* section right after it. The *Let’s get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan for in-network and out-of-network coverage.

Table of Contents

	Page
Welcome	
Let's get started!.....	1
Some notes on how we use words.....	1
What your plan does-providing covered benefits.....	1
How your plan works-starting and stopping coverage.....	1
How your plan works while you are covered in-network.....	1
How your plan works while you are covered out-of-network.....	3
How to contact us for help.....	3
Your member identification (ID) card.....	3
Who the plan covers.....	4
Who is eligible.....	4
When you can join the plan.....	4
Who can be on your plan (who can be your dependent).....	4
Adding new dependents.....	5
Special times you and your dependents can join the plan.....	6
Effective date of coverage.....	6
Medical necessity and precertification requirements.....	7
Medically necessary; medical necessity.....	7
Precertification.....	7
Eligible health services under your plan.....	10
Preventive care and wellness.....	10
Physicians and other health professionals.....	15
Hospital and other facility care.....	17
Emergency services and urgent care.....	19
Specific conditions.....	20
Specific therapies and tests.....	28
Other services.....	33
Outpatient prescription drugs.....	38
What you and your dependents need to know about your outpatient prescription drug plan.....	38
How to access network pharmacies.....	38
How to access out-of-network pharmacies.....	39
What outpatient prescription drugs are covered.....	40
Other services.....	41
How you and your dependents get an emergency or urgent care prescription filled.....	43
Where your schedule of benefits fits in.....	43
What your plan doesn't cover - some eligible health service exceptions.....	46
General exceptions.....	46
Additional exceptions for specific types of care.....	51
Preventive care and wellness.....	51
Physicians and other health professionals.....	51
Hospital and other facility care.....	51
Emergency services and urgent care.....	52
Specific conditions.....	53
Specific therapies and tests.....	54
Other services.....	54
Outpatient prescription drugs.....	57

Who provides the care	60
Network providers	60
Your PCP	60
Our national infertility unit	61
Out-of-network providers	61
Keeping a provider you and your dependents go to now (continuity of care)	62
What the plan pays and what you pay	64
The general rule	64
Important exception-when your plan pays all	64
Important exceptions-when you pay all.....	64
Special financial responsibility	65
Where your schedule of benefits fits in	65
When you disagree - claim determinations procedures/complaints and appeals	66
Claim procedures	66
Types of claims and communicating our claim decisions.....	67
Adverse benefit determinations	68
The difference between a complaint and an appeal.....	69
Appeals of adverse benefit determination.....	69
Timeframes for deciding appeals	70
Appeals of Inpatient substance use disorders.....	71
Exhaustion of appeals process	72
External review.....	72
Recordkeeping.....	74
Fees and expenses.....	74
Coordination of benefits.....	75
Key terms	75
Here's how COB works	76
Determining who pays under a health plan	77
How are benefits paid?	78
How COB works with Medicare.....	80
How this plan works with automobile plans for automobile related injuries	81
Determining who pays when there is an automobile plan for automobile related injuries	82
Other health coverage updates - contact information.....	82
Right to receive and release needed information.....	82
Right to pay another carrier	82
Right of recovery	83
Recovery rights related to Worker's Compensation	83
When coverage ends	84
When will your coverage end?	84
When will coverage end for any dependents?	85
Why would we end you and your dependents coverage?	85
When will we send you a notice of your coverage ending?	86
Special coverage options after your plan coverage ends	87
Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights.....	87
Continuation of coverage for other reasons	90
Over-age dependent continuation	93
Discontinuance and replacement provisions	96
A bit of this and that.....	98
Administrative provisions *	98
Coverage and services.....	98
Honest mistakes and intentional deception.....	99

Some other money issues	100
Your health information	101
Glossary	103

Schedule of benefits

Issued with your booklet-certificate

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean **Aetna**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical medical language that is familiar to medical **providers**. If you need help with any of the terms, call the Member Services toll-free number on your ID card.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

This plan provides network and out-of-network coverage for medical, vision and pharmacy insurance coverage.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage:

- Helps you and your dependents get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
 - You will pay less cost share when you use a **network provider**.
1. **Eligible health services**
Physicians and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you and your dependents want. Sometimes it doesn't cover health care services your physician will want you and your dependents to have.

So what are **eligible health services**? They are health care services that meet these three requirements:
 - They are listed in the *Eligible health services under your plan* section.
 - They are not carved out in the *What your plan doesn't cover – some eligible health service exceptions* section. (We refer to this section as the “exceptions” section.)
 - They are not beyond any limits in the schedule of benefits.

2. **Aetna's network of providers**

Aetna's network of physicians, **hospitals** and other health care **providers** are there to give you and your dependents the care you and your dependents need. You and your dependents can find **network providers** and see important information about them most easily on our online **provider directory**. Just log into your Aetna secure member website at www.aetna.com.

You and your dependents are encouraged to choose a **primary care physician** (we call that physician your **PCP**) to oversee your and your dependents' care. Your and your dependents' **PCP** will provide your and your dependents routine care, and send you and your dependents to other **providers** when you and your dependents need specialized care. You and your dependents don't have to access care through your and your dependents' **PCP**. You and your dependents may go directly to network **specialists** and **providers** for **eligible health services**. Your plan often will pay a bigger share for **eligible health services** that you and your dependents get through your and your dependents' **PCP**, so choose a **PCP** as soon as you and your dependents can.

For more information about the network and the role of your and your dependents' **PCP**, see the *Who provides the care* section.

3. **Paying for eligible health services– the general requirements**

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**.
- You and your dependents get the **eligible health service** from a **network** or **out-of-network provider**.
- You and your dependents or your and your dependents' **provider** **precertifies** the **eligible health service** when required.

You and your dependents will find details on **medical necessity** and **precertification** requirements in the *Medical necessity and precertification requirements* section.

4. **Paying for eligible health services– sharing the expense**

Generally your plan and you and your dependents will share the expense of you and your dependents **eligible health services** when you and your dependents meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you and your dependents will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

5. **Disagreements**

We know that people sometimes see things differently.

The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an "independent utilization review organization" or IURO for short, will make the final decision for us.

For more information see the *When you disagree - claim determination procedures/complaints and appeals* section.

How your plan works while you are covered out-of-network

The section above told you and your dependents how your plan works while you and your dependents are covered in-network. You and your dependents also have coverage when you and your dependents want to get your and your dependents' care from **providers** who are not part of the **Aetna** network. It's called out-of-network coverage.

Your and your dependents' out-of-network coverage:

- Means you and your dependents can get care from **providers** who are not part of the **Aetna** network.
- Means you and your dependents may have to pay for services at the time that they are provided. You and your dependents may be required to pay the full charges and may be responsible to submit a claim for reimbursement to us that you paid directly to a **provider**.
- Means that when you and your dependents use out-of-network coverage, it is your and your dependents' responsibility to start the **precertification** process with **providers**.
- Means you and your dependents will pay a higher cost share when you and your dependents use an **out-of-network provider**.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section.
- **Out-of-network providers** and any exceptions in the *Who provides the care* section.
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your and your dependents' questions. You and your dependents can contact us by logging onto the Aetna secure member website at www.aetna.com.

Register for Aetna member website, our secure Internet access to reliable health information, tools and resources. Aetna member website online tools will make it easier for you and your dependents to make informed decisions about health care, view claims, research care and treatment options, and access information on health and wellness.

You and your dependents can also contact us by:

- Calling **Aetna** Member Services at the toll-free number on your ID card
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156.

Your identification (ID) card

Your ID card tells physicians, **hospitals**, and other **providers** that you and your dependents are covered by this plan. Show your ID card each time you and your dependents get health care from a **provider** to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your ID card. If you misuse your card we may end your coverage.

We will mail you your ID card. If you haven't received it before you need **eligible health services**, or if you've lost it, you can print a temporary ID card. Just log into your Aetna secure member website at www.aetna.com.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

The policyholder decides and tells us who is eligible for health care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At the end of any waiting period the policyholder requires
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself and your dependents when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your “dependents”.)

- Your legal spouse, including a civil union partner as defined by New Jersey State law. We also mean civil union or civil union partner when we talk about:
 - Husband/wife (spouse)
 - Family/immediate family
 - Dependent
 - Next of kin
- We mean civil union when we talk about:
 - Marriage
 - Widow/widower/widowed
- Your domestic partner established in New Jersey prior to February 19, 2007 as evidenced by a copy of an Affidavit of Domestic Partnership filed with the local registrar and marked as “filed”.
- A domestic partnership providing all of the rights and benefits of marriage valid in another state will be valid for this benefit plan.
- Your dependent children – your own or those of your spouse or domestic partner
 - The children must be under 26 years of age, and they include:
 - o Biological children
 - o Stepchildren
 - o Legally adopted children, including any children placed with you for adoption
 - o Foster children, including any children placed with you or your spouse or your domestic partner for proposed adoption
 - o Children you or your spouse or your domestic partner are responsible for under a qualified medical support order or court-order (whether or not the child resides with you or your spouse or your domestic partner and whether or not the child resides inside the **service area**)
 - o Children you or your spouse or domestic partner are responsible for under court-order

- Grandchildren in your or your spouse's or domestic partner's court-ordered custody
- Any other child with whom you or your spouse or your domestic partner have a parent-child relationship
- Any unmarried dependent child or dependent child who is not in a civil union or a domestic partnership age 26 and over but under 31 years of age, chiefly dependent upon you or your spouse or domestic partner for support and maintenance
- Any unmarried dependent child or dependent child who is not in a civil union or a domestic partnership age 26 and over but under 31 years of age, chiefly dependent upon you or your spouse or domestic partner for support and maintenance, and attending a recognized college or university, trade, or secondary school on a full-time and part-time basis

Coverage may be continued for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Your or your dependent's eligibility for Medicaid shall not prohibit eligibility for, or the provision of, benefits under this **certificate**.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
 - We must receive your completed enrollment information not more than 30 days after the date of your marriage.
 - Ask the policyholder when benefits for your spouse will begin. It will be:
 - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
 - Within 30 days of the date of your marriage.
- A domestic partner – If you enter into a domestic partnership valid in another state, you can put your domestic partner on the plan.
 - We must receive your completed enrollment information not more than 30 days after the date of enter into the domestic partnership
 - Ask the policyholder when benefits for your domestic partner will begin. It will be:
 - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
 - Within 30 days of the date of entering into the domestic partnership.
- A newborn child - Your newborn child is covered on your health plan for the first 60 days after birth.
 - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
 - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
 - If you miss this deadline, your newborn will not have health benefits after the first 60 days.
- An adopted child - A child or a child who is placed with you for adoption – A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete. Placed for adoption means you or your spouse or your domestic partner have legal obligation for all or part of the support of a child in anticipation of adoption of the child. A child who is placed for adoption will be treated as a dependent from the date the child was placed for adoption.
 - To keep your adopted child covered, we must receive your completed enrollment information within 30 days after the adoption.
 - If you miss this deadline, your adopted child will not have health benefits after the first 30 days.

- A stepchild - You may put a child of your spouse or domestic partner on your plan.
 - You must complete your enrollment information and send it to us within 30 days after the date of your marriage with your stepchild's parent.
 - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as (excluding the addition of a dependent as addressed in *Adding a new dependent provision*):

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent
- Your spouse or domestic partner covered you and your other eligible dependents under another health plan; and now that other coverage has ended for reasons other than gross misconduct

We must receive your completed change form from you within 31 days of the date of the above change in status.

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
 - You were covered by another health plan, and now that other coverage has ended.
 - You previously declined coverage in writing.
 - You had COBRA, and now that coverage has ended.
- When a court orders that you cover a current spouse or domestic partner or a minor child on your health plan
- You or your dependents lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.

We must receive your completed enrollment information within 31 days of the date of the event or date on which you no longer have the other coverage mentioned above. However, the completed enrollment form may be submitted within 60 days of the event when:

- You lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You become eligible for state **premium** assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan

Effective date of coverage

- Your coverage will be in effect as of the date you become eligible for health benefits.
- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of domestic partnership valid in another state, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

Medical necessity and precertification requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services**. See the *Eligible health services under your plan* and *exceptions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible health services** only if the general requirements are met. They are:

- The **eligible health service** is **medically necessary**.
- You and your dependents' **provider** **precertifies** the **eligible health service** when required.

This section addresses the **medical necessity** and **precertification** requirements.

Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you and your dependents to receive a **covered benefit** under this plan.

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**." That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

Precertification (read this provision carefully to learn how to avoid possible benefit reductions)

You and your dependents need pre-approval from us for some **eligible health services**. Pre-approval is also called **precertification**.

Precertification is not required for **substance use disorders** treatment for the first 180 days of treatment.

In-network

Your and your dependents' **physician** is responsible for obtaining any necessary **precertification** before you and your dependents get the care. If your and your dependents' **physician** doesn't get a required **precertification**, we won't pay the **provider** who gives you and your dependents the care. You won't have to pay either if your and your dependents' **physician** fails to ask us for **precertification**. If your and your dependents' **physician** requests **precertification** and we refuse it, because it is not a covered benefit, you and your dependents can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important exceptions – when you pay all* section.

Out-of-network

When you and your dependents go to an **out-of-network provider**, it is your and your dependents' responsibility to obtain **precertification** from us for any services and supplies on the **precertification** list. If you and your dependents do not **precertify**, your and your dependents' benefits may be reduced. Refer to your schedule of benefits for this information. The list of services and supplies requiring **precertification** appears later in this section. Also, for any **precertification** benefit reduction that is applied see the schedule of benefits *Precertification benefit reduction* section.

Precertification should be secured within the timeframes specified below. For **emergency services**, **precertification** is not required, but you should notify us within the timeframes listed below. To obtain **precertification**, call us at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your dependents, your and your dependents' physician or the facility will need to call and request precertification at least 14 days before the date you and your dependents are scheduled to be admitted.
For an emergency admission :	You, your dependents, your and your dependents' physician or the facility must call within 48 hours or as soon as reasonably possible after you and your dependents have been admitted.
For an urgent admission :	You, your dependents, your and your dependents' physician or the facility will need to call before you and your dependents are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness , the diagnosis of an illness , or an injury .
For outpatient non-emergency medical services requiring precertification :	You, your dependents or your and our dependents' physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to you and your dependents and your and your dependents' **physician** of the **precertification** decision, where required by state law. If the **precertified** services are approved, the approval is valid for 180 days as long as you and your dependents remain enrolled in the plan.

When you and your dependents have an inpatient admission to a facility, we will notify you, your dependents, your and your dependents' **physician** and the facility about the **precertified** length of **stay**. If the **physician** recommends that the **stay** be extended, additional days will need to be **precertified**. You, your dependents, your **physician**, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended **stay**. You and your dependents and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered benefits**, the notification will explain why and how our decision can be appealed. You, your dependents or your **provider** may request a review of the **precertification** decision. See the *When you disagree - claim decisions and appeals procedures* section.

What types of services require precertification?

Precertification is required for the following types of services and supplies:

Inpatient services and supplies
Stays in a hospital
Stays in a skilled nursing facility
Stays in a rehabilitation facility
Stays in a hospice facility
Stays in a residential treatment facility for treatment of mental disorders
Stays in a residential treatment facility for treatment of substance use disorder beginning on the 181 st day of the plan year whether the days are consecutive or intermittent partial days or full days
Bariatric surgery (obesity)

Outpatient services and supplies
Applied behavior analysis
Cosmetic and reconstructive surgery
Non-emergency transportation by fixed wing airplane
Intensive outpatient program (IOP) – mental disorder diagnoses
Intensive outpatient program (IOP) – substance use disorders diagnoses beginning on the 181 st day of the plan year whether the days are consecutive or intermittent, partial days or full days
Partial hospitalization treatment – mental disorder diagnoses
Partial hospitalization treatment – substance use disorders diagnoses beginning on the 181 st day of the plan year whether the days are consecutive or intermittent, partial days or full days
Psychological testing/neuropsychological testing
Transcranial magnetic stimulation (TMS)

Certain **prescription drugs** are covered under the medical plan when they are given to you and your dependents by your and your dependents' **physician** or health care facility. The following information applies to these **prescription drugs**:

For certain drugs, your and your dependents' provider needs to get approval from us before we will cover the drug. This is called **precertification**. Sometimes the requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

Contact us or go online to get the most up-to-date **precertification** requirements.

How do you get a medical exception?

Sometimes you and your dependents or your and your dependents' **prescriber** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. Any exception is based upon an individual and is a case-by-case decision that will not apply to other members.

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital stays**. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- **Physician** care generally is covered but **physician** care for **cosmetic surgery** is never covered. This is an exception (exclusion).
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about these exceptions in the *What your plan doesn't cover some eligible health service exceptions* section, and about the limitations in the schedule of benefits.

Important note:

Sex-specific **eligible health services** are covered when medically appropriate, regardless of identified gender.

We've grouped the health care services below to make it easier for you to find what you're looking for.

Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you and your dependents are well.

Important notes:

1. You will see references to the following recommendations and guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- United States Preventive Services Task Force
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.
3. Gender-specific preventive care *benefits* include **eligible health services** described below regardless of the sex you and your dependents were assigned at birth, your and your dependents' gender identity, or your and your dependents' recorded gender.
4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your and your dependents' **physician** or contact Member Services by logging on to the secure member website at www.aetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine physical exams

Eligible health services include office visits to your or your dependents' **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness or injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings by blood lead measurement for lead poisoning for children, including:
 - Confirmatory blood lead testing, as specified by the New Jersey Department of Health
 - Medical evaluation
 - Any necessary medical follow-up treatment for lead poisoned children
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services on topics such as:
 - o Interpersonal and domestic violence
 - o Sexually transmitted diseases
 - o Human Immune Deficiency Virus (HIV) infections
 - Screening for gestational diabetes for women
 - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns:
 - An initial **hospital** checkup
 - Hearing loss screenings by appropriate electrophysiologic screening measures
 - Periodic monitoring for delayed onset hearing loss

Health wellness promotion programs

Eligible health expenses include charges made in a health promotion program through health wellness examinations and counseling for the following services. These services are recommended at certain time periods of your or your dependents' life which are shown on your schedule of benefits.

- Blood tests to determine:
 - Blood hemoglobin
 - Blood glucose
 - Blood pressure
 - Blood cholesterol
- Stool examination for the presence of blood
- Colon exams:
 - A left-sided colon examination of 35 to 60 centimeters
 - A routine diagnostic examination, including but not limited to, a digital rectal examination and a prostate-specific antigen test
- A glaucoma eye test
- A pap smear
- A mammogram
- A digital tomosynthesis, if you are age 40 or older
- Recommended immunizations
- Lifestyle behavior counseling including:
 - Smoking control
 - Nutrition and diet recommendations
 - Exercise plans

- Lower back protection
- Weight control
- Immunizations practices
- Breast self-examination
- Testicular self-examination
- Seatbelt usage in motor vehicles

Preventive care immunizations

Eligible health services include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the New Jersey Department of Health and Senior Services.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your or your dependents' employment or travel.

Well woman preventive visits

Eligible health services include your and your dependents' routine:

- Well woman preventive exam office visit to your and your dependents' **physician, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN**. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness or injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive screening and counseling services

Eligible health services include screening and counseling by your or your dependents' **health professional** for some conditions. These are obesity, **substance use disorders**, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you and your dependents get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**

Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Substance use disorders**

Eligible health services include the following screening and counseling services to help prevent or reduce the **substance use disorders**:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

Eligible health services include the following screening and counseling services to help you and your dependents to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits;
- **Tobacco cessation prescription and over-the-counter drugs**
 - o **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
 - Cigars
 - Smoking tobacco
 - Snuff
 - Smokeless tobacco
 - Candy-like products that contain tobacco
- **Sexually transmitted infection counseling**
Eligible health services include the counseling services to help you and your dependents prevent or reduce sexually transmitted infections.
 - **Genetic risk counseling for breast and ovarian cancer**
Eligible health services include counseling and evaluation services to help you or your dependents assess whether or not you or your dependents are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- A digital tomosynthesis, if you are age 40 or older
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Computed tomography colongraphy
- Lung cancer

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
- The state laws and regulations that govern this plan.

If you or your dependents need a routine gynecological exam performed as part of a cancer screening, you and your dependents may go directly to a **network provider** who is an OB, GYN or OB/GYN.

Prenatal care

Eligible health services include your or your dependents' routine prenatal physical exams as preventive care, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You and your dependents can get this care at your or your dependents' **physician's, PCP's, OB's, GYN's**, or OB/GYN's office.

Important note:

You should review the benefit under *Eligible health services under your plan- Maternity and related newborn care* and the *What your plan doesn't cover – some eligible health service exceptions* sections of this booklet-certificate for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you and your dependents get it in an individual or group setting. Your plan will cover this counseling only when you and your dependents get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

Eligible health services include renting or buying **durable medical equipment** you or your dependents need to pump and store breast milk as follows:

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your or your dependents newborn child is confined in a **hospital**.
- The buying of:
 - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every three years, or
 - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pump supplies and accessories

Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you and your dependents purchase or rent for personal convenience or mobility.

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

Eligible health services include counseling services provided by a **physician**, **PCP**, **OB**, **GYN**, or **OB/GYN** on contraceptive methods. These will be covered when you and your dependents get them in either a group or individual setting.

Devices

Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

Voluntary sterilization

Eligible health services include charges billed separately by the **physician** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:

See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

Physicians and other health professionals

Physician services

Eligible health services include services by your or your dependents' **physician** to treat an **illness** or **injury**. You and your dependents can get those services:

- At the **physician's** office
- In your or your dependents' home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine** and/or **telehealth**

Important note:

Your plan covers **telemedicine** and/or **telehealth** only when you get your consult through a **provider** who has contracted with **Aetna** to offer these services. All in-person office visits covered with a **behavioral health provider** are also covered if you use **telemedicine** and/or **telehealth** instead. **Telemedicine** and/or **telehealth** is not the same as an office visit and may have different cost sharing. See the schedule of benefits for specific plan details.

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your or your dependents' **surgery**
- Your or your dependents' surgeon who you or your dependents' visit before and after the **surgery**
- Another surgeon who you and your dependents go to for a second opinion before the **surgery**

Alternatives to physician office visits

Walk-in clinic

Eligible health services include health care services provided at **walk-in clinics** for:

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license

Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care.

The types of **hospital** care services that are eligible for coverage include:

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room because of your or your dependents' medical condition.
- Services of **physicians** employed by the **hospital**
- Operating and recovery rooms
- Intensive or special care units of a **hospital**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a **hospital**.

Anesthesia and hospital charges for dental care

Eligible health services are provided to you and your dependents if severely disabled and requiring dental services, or to a covered dependent child age 5 or under who requires dental services:

- General anesthesia and hospitalization
- A medical condition requiring hospitalization or general anesthesia, regardless of where dental services are provided

Alternatives to hospital stays

Outpatient surgery and physician surgical services

Eligible health services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery center** or a **hospital's** outpatient department.

Important note:

Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician or PCP** services and not for a separate fee for facilities.

